Participating Provider Manual

Revised March 2020

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Linkia Provider Manual

The Linkia Provider Manual is an extension of the Linkia Provider Agreement. The Linkia Provider Manual contains information regarding Linkia's Policies and Procedures. The information contained in this Manual applies to the Linkia Independent Provider Network. Providers in the Linkia Independent Provider Network are contractually obligated to follow the policies and procedures outline in the Manual.

Welcome to the Linkia Network! Linkia was designed to help reduce administrative expenses by providing simplified electronic billing and remittance, and to establish a connection between its healthcare company partners and O&P clinicians.

Provider Service As a participant in the Linkia provider network, you have access to a wealth of resources to aid you in the contracting and administrative aspects of O&P care delivery. The Customer Service team is your first point of contact for any questions you may have. For inquiries about specific claims, submit an online form here: https://linkia.secure.force.com/customerservice. This link can also be found on www.linkia.com ◊ Providers ◊ LinkSpan Provider Tools ◊ Customer Service Electronic Forms.

Our Customer Service representatives are available Monday through Friday from 8:30 a.m. to 7:00 p.m. (EST) to help you.

Linkia Provider Service
Phone: 877-754-6542
Option #3
Fax: 512-201-6060

Network Management

Out Network Management Department serve as your liaison and resource as you service the patients of Linkia clients. Their role includes:

- Tracking and trending service delivery
- Assisting with questions or issues related to payer contracts
- Making periodic contact and/or visits with your office or facility in accordance with contract and regulatory requirements
- Recruiting and managing provider networks
- Training providers and staff on network operations
    - Orientation upon joining the Linkia Network
    - New Linkia contract implementations
    - Ongoing updates of payer and Linkia policies/procedures
- Communication with provider on an ongoing basis through:
    - Provider Alerts
    - Ongoing Updates

Linkia Web Site

The Linkia Web Site (www.linkia.com) provides a convenient way to obtain valuable information regarding Linkia's processes and procedures. At the site, you'll find:

3 – Credentialing & Re-credentialing

Linkia is committed to ensuring that all patients receive O&P care from qualified professionals in a safe physical environment. This is accomplished through a variety of mechanisms; including Linkia's credentialing and re-credentialing process.

Each facility must accommodate patients that may be physically challenged and must comply with all appropriate health, fire and occupancy codes. The credentialing process also includes validation of liability coverage, business licenses, facility accreditation, practitioner licenses (where applicable), and Medicare participation and practitioner certifications.

Credentialing Process

Linkia has adopted the facility accreditation criteria and quality standards set forth by CMS as the minimum requirements.

Linkia's initial credentialing process begins with the submission of a completed credentialing application. Each application must include copies of:

- License(s): business and/or clinical
- Malpractice insurance and history
- Accreditation and Certification documents: facility and practitioner
- Attestation Form signed – for facility and for each practitioner
- Medicare Approval letter
- Medicaid letter (if applicable)

As any of these documents expire, it is imperative that Linkia receive updated information as close to the renewal date as possible.

Upon receipt of your completed application and necessary documentation, Linkia will verify all information and submit your application to the Credentialing Committee for evaluation and a decision. You will be contacted if additional information is needed.

In order to be considered an *active* participant in the Linkia network, providers must have an *executed contract* and *Credentialing Committee approval.* You will be notified upon completion of the credentialing process.

Re-credentialing Process

Linkia re-credentials all network providers at least every three years. The re-credentialing process includes review and/or verification of:

- License(s)
- Facility Accreditation and Practitioner Certification
- Malpractice insurance

- Professional liability claims history
- Attestation Form signed – for facility and for each practitioner
- Updated Medicare/Medicaid letters if facility demographics have changed

Facility Accreditation and Practitioner Certification and Billing Eligibility

All newly recruited facilities that are not accredited, must meet all other credentialing criteria, including demonstration that practitioners are certified with a deemed agency in accordance with specialty type and/or licensed in accordance with state requirements. Sites that are accepted into the network have 90 days to apply for facility accreditation. Submit validation that your application is in process to RCMBilling@Hanger.com for fax to 512-201-6060. Upon receipt of the accreditation certificate, forward a copy to:

Hanger Inc.
c/o Linkia, LLC
PO Box 650846
Dallas, TX 75265-0846
Attention: Credentialing Department

Failure to apply or achieve accreditation subjects facility to removal from the Linkia Network. In addition, services billed must be in alignment with the facility accreditation. Consequences for billing outside of accreditation could include corrective action planning, monthly monitoring and potential network termination.

Applicant Rights

An applicant has the right to review negative findings obtained during the primary source verification process. They have the right to submit documentation to correct erroneous information obtained by Linkia. Applicants may obtain information about the status of their Application upon their request. Applicants are not able to review personal or professional references, or other information that is peer review protected. Linkia will notify Applicant in writing within 30 days of identifying any information that varies substantially from the information provided by the Applicant. Applicant must submit any corrections in writing to Linkia within 30 days of the Applicant's notification of the discrepancy.

Appeal Rights

Linkia permits appeals of adverse credentialing decisions only to the extent required by the law, the Linkia Participation Agreement, and/or Provider Manual. Linkia will notify the initial applicant or participating provider of any adverse decision through the credentialing process along with their rights to appeal. The provider or their representative, including legal counsel, must submit an appeal in writing to Linkia within 30 calendar days of the notification of an adverse credentialing decision. Linkia responds in writing within 15 calendar days following the next credentialing committee meeting. If the first level denial is upheld then a second level appeal is available and must be addressed within 15 calendar days of the notification of an adverse credentialing decision. If the second level appeal is upheld then the Credentialing

Committee will forward any third level appeal to the Peer Review Committee for final resolution. The Peer Review Committee will respond 15 calendar days following their next meeting.

Appeal Protection

Linkia does not discriminate against any provider based on age, race, sex, color, religion, national origin, disability, veteran status, sexual orientation, and status with respect to public assistance or other characteristics protected under state, federal or local law. Linkia is committed to a diverse network of providers with respect to sex, race, veteran status and disability in its selection of providers seeking participation or continued participation into Linkia's network. Linkia will investigate and work through resolution any and all complaints regarding applicant discrimination within the credentialing and re-credentialing process. Should Linkia suspect discrimination in any form detailed above, an investigation will also be launched and followed through the Peer Review Committee complaint process.

4 – Administrative Functions

Verifying Insurance Eligibility/Benefit Coverage

Patient eligibility rules vary in accordance with their plan design and benefits. It is important to verify patient eligibility and benefits *on,* or *just prior to,* the date of service. Failure to verify patient's eligibility and benefits could result in a claim's ineligibility without justification for appeal.

At the initial visit, the patient ID card should be collected, copied and verified. For most insurance carriers, you will need to contact the payer *directly* to verify patient eligibility and benefits. This process may vary, based on carrier contracts. You will be notified of any exceptions or changes

Verification of eligibility and benefits should also be done on *all* subsequent patient visits. Patient eligibility may change at any time, so it is essential to ensure that you have the most up-to-date information prior to delivering service and submitting claims. Linkia is not responsible for payer denials of any services based on patient's eligibility.

Why do a Benefits Check?

- Increase administrative efficiencies
- Decrease denial/appeals
- Avoid resubmission of corrected claims
- Manage accounts receivable
- Increase patient satisfaction
- Accurately communicate financial responsibility to the patient

Submitting Claims

Guidelines

- Linkia strongly recommends that all claims for contracted payers are submitted within 15 days of service delivery.
- Failure to submit claims to Linkia less than 15 days prior to the payer's timely filling requirement could result in a claim's ineligibility without justification for an appeal.
- Linkia is not responsible for claims submitted outside of the payer's filling limits.
- Any file adjustments/changes to claims must be submitted within forty five (45) days of the Original EOB Date or within designated payer/state regulations. Adjustments submitted beyond 45 days will not be accepted and the original claim will be deemed final.

Electronic Claims Submission

Linkia strongly recommends electronic claim submission and will support providers in their efforts. To activate electronic claim submissions to Linkia, contact RCMBilling@Hanger.com for details. Once activated claims are to be submitted electronically as required by Linkia excluding any secondary claims or claims that require clinical documentation.

Alternative to Electronic Claims Submission (Paper Submission)

To ensure timely processing, submit clean claims with appropriate Linkia Batch Cover Sheet, in accordance with CMS guidelines on a CMS 1500 form. The CMS 1500 on the next page identifies all fields required for processing. Incomplete claims will not meet clean claim guidelines and will be returned without processing. Refer to the Form below for help in defining the required fields.

Claim Attachments for Paper Submission

Include the following with each claim submission:

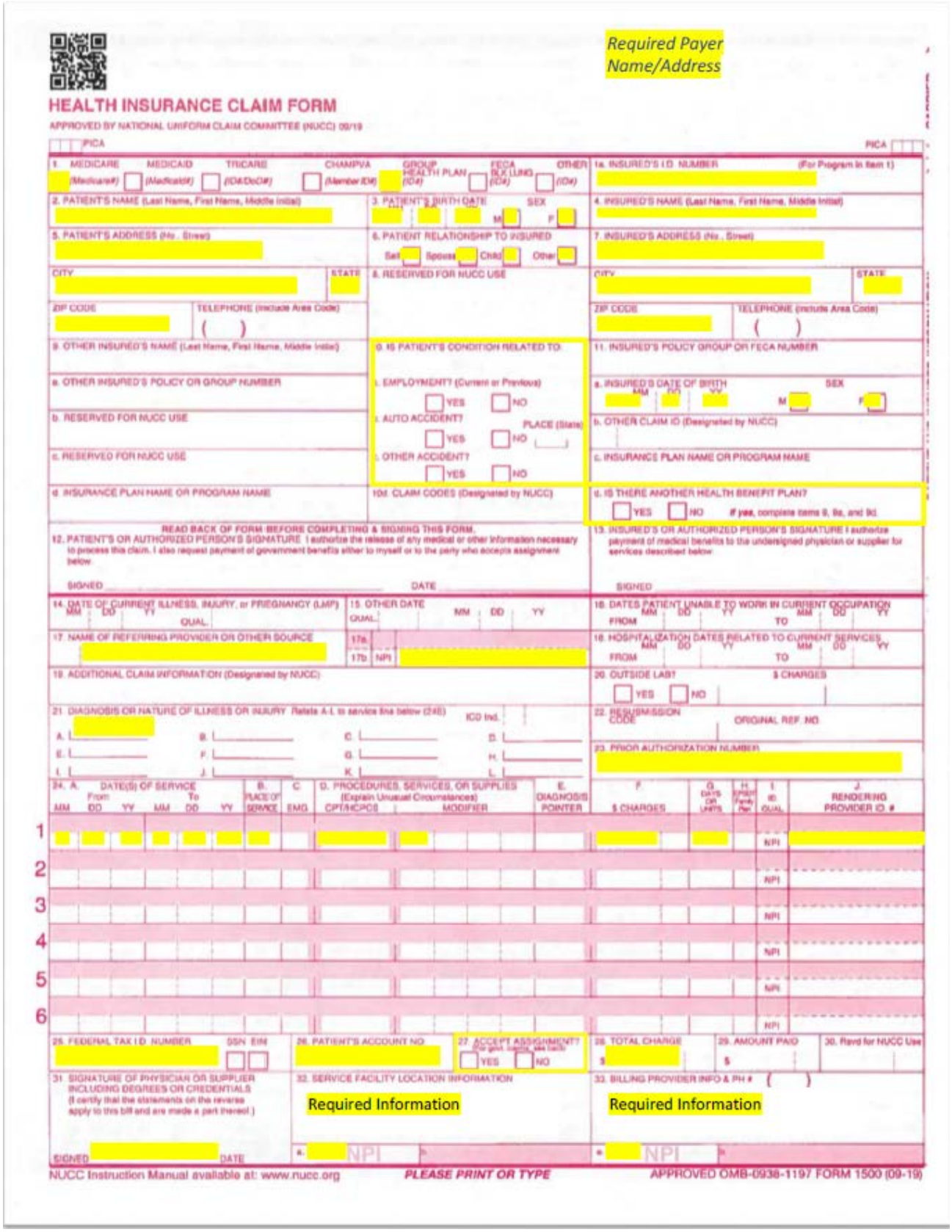
- A copy of the patient's ID card, front and back
- Medical documentation, as applicable
- Primary EOB, if applicable

Additional Claim Information that may be requested

In some instances, additional information may be required for claims processing, such as:

- Other insurance information (e.g., payer's EOB)
- Medical necessity documentation
- Proof of timely filing

Required Fields Highlighted



Paper Claim Submission Address

The payer name (as it appears on Contract Summary), Linkia name, and address should be included in the upper right-hand corner of CMS 1500. Fax, Secure Email or Mail completed CMS 1500 form(s) and attachments, with a Claims Batch Cover Sheet, to the following address:

Hanger, Inc.
c/o Linkia, LLC
PO Box 650846
Dallas, TX 75265-0846
Fax: (512) 201-6060
Email RCMBilling@Hanger.com

Corrected and Resubmitted Claims

If you need to submit a corrected claim or resubmit a claim for any reason, please make notation on top of claim and send to the following address, fax or secure email:

Hanger, Inc.
c/o Linkia, LLC
10910 Domain Drive #300
Austin, TX 78758
Fax: (512) 201-6060
Email RCMBilling@Hanger.com

Claims Payment

Payment for contracted services will be issued to providers following Linkia's receipt of payment from the payer. Upon inquiry to the payer, you may be provided with information regarding the business relationship between the payer and Linkia. Your contractual relationship and payment is reflected in the Linkia remittance advice. Payment will equal the lesser of contract allowable or billed charges.

Explanation of Remittance Advice

A Linkia Remittance Advice (RA) will accompany each claim payment. The RA itemizes payment information such as patient responsibility amounts, contracted discounts from usual and customary charges, payment amounts, date(s) of service, denial and adjustment codes.

Be aware that payer RAs will vary from the Linkia RA. Payer RAs reflect Linkia's contractual relationship with the payer, not the provider.

	Payer RA	Linkia RA
Contract allow between Linkia and payer	√	
Contract allow between Linkia and provider		√
Patient responsibility	√	√
Date of service	√	√
Detail of services provided	√	√
Denial and adjustment codes	√	√
Final Paid Amount = contract allow – patient responsibility		√

Coordination of Benefits (COB)

The provider is responsible for establishing availability of additional insurance. Submit the claim and associated EOBs reflecting payment from the primary payer to:

Hanger, Inc.
c/o Linkia, LLC
10910 Domain Drive #300
Austin, TX 78758
Fax: 512-201-6060
Email: RCMBilling@Hanger.com

Billing of Members

- Collect applicable deductibles and coinsurance, in accordance with payer requirements
- Inform members of responsibility to pay for non-covered services, and obtain a signed Advance Beneficiary Notice (ABN) when applicable.
- Members may not be billed for:
  - The difference between the provider's charge and Linkia's contracted fee schedule
  - Penalties incurred as result of provider's failure to follow payer protocol
    For additional information regarding billing of member, refer to the Linkia Provider Agreement, section 4.9-Member Hold Harmless.

Payment Reduction

Linkia may reduce payments and will notify providers of any such deductions. This may occur when:

- Duplicate payments are issued for services or supplies
- Overpayment is made in excess of contracted fees

In accordance with your Linkia Provider Participation Agreement, Section 4.5 "Refunds and Overpayments," in the event of an overpayment by a Payer, or Linkia; the Payer or Linkia may request a refund of the overpaid amount. If the Payer or Linkia does not receive a refund within thirty (30) days, Linkia will offset the amount of the request until balance is paid in full.

Claim and Reimbursement Status Inquiry

- Payment Status: Contact payer via phone or Web site.
  - Confirm claim receipt
  - Determine status of claim adjudication

- Payment Accuracy: Contact Linkia
  - Go to https://linkia.secure.force.com/customerservice

- This link can also be found on www.linkia.com → Providers → LinkSpan Provider Tools → Customer Service Electronic Forms

Appeals Process

Provider is responsible for filing appeals directly with the payer. Refer to the payer's provider manual or payer's Web site for information regarding the appeals process.

Claims Submission Troubleshooting

There are a number of claims issues that may result in delayed claim submission and processing.

Potential Barriers to Expedited Claim & Payment Processing			
Issue	**Example**	**Claim Implication**	**Recommended Action**
Invalid Procedure Code	Code or modifier is invalid per CMS guideline or excluded from contract	Claim rejected	Resubmit claim with proper coding
Invalid Date of Service	Claim date of service is prior to Linkia contract effective date	Claim rejected	Submit claim directly to payer using facility TIN
Incomplete CMS 1500	Non-clean claim: claim is missing data elements	Claim rejected	Review and complete all fields prior to re-submitting claim
Non-network provider	Facility is not credentialed at time claim is received	Claim rejected	Contact Linkia Network Manager

LinkSpan Powered by PaySpan Health

Linkia is pleased to offer an enhanced payment and reconciliation solution through LinkSpan. This service enables you to expedite payment through electronic deposits with complete remittance details. You will have numerous online capabilities to search claims and remittance details and produce custom reports.

With *LinkSpan*, you can go online at your convenience to:

- Manage accounts
- Reconcile payments
- View payments online
- View account configurations
- Administer user rights
- Access individual reports

You can access this payment remittance feature, as well as a detailed User Guide, through the Linkia Web site at www.linkia.com → Providers → LinkSpan Provider Tools → Payment Status,

or at https://payspanhealth.com/linkia/ . Signing up for LinkSpan is simple, secure, and will only take five to ten minutes.

Refunds

Refunds are typically initiated by payers for reasons such as overpayment and coordination of benefits. Within 48 hours of receipt of a refund request letter from the payer, Linkia will fax it to the rendering service provider. Along with the payer letter, the provider will receive additional details to assist in processing. ***It is the provider's responsibility to work directly with the payer to resolve any dispute about the refund request.*** All appeals to overturn the decision for the refund are between the provider and payer. If after exhausting the appeal process and the payer still requires a refund, the provider must pay Linkia within 30 days of the final decision. As stated in the Participating Provider Agreement, Linkia Section 4.5 "Refunds and Overpayments," Linkia has the right to offset future payments up to the amount of the refund request. Non-payment could result in activation of the provider termination process.

Notification and Authorization

Provider is responsible for complying with the payer's notification process. Provider is responsible for obtaining authorization from the payer for services that require authorization. Refer to the payer's Web site for information for services that require authorization and the notification process. Authorization should be obtain under the Linkia TIN – 200800593.

Demographic Changes

Linkia providers are required to notify Linkia in writing within ten (10) days of any changes in the ownership, corporate status, name, location, tax identification number, Medicare or Medicaid numbers, change in services, change in office hours, and change in billing (w9) or authority to do business of Provider, change in staff credentials; or any other situation or factor that may adversely affect Provider's performance or ability to provide Covered Services to Members in compliance with the terms and conditions of this Agreement. Providers can submit a Linkia Independent Change Request Notification found on the Linkia website at www.linkia.com under Providers/LinkSpan Provider Tools/Change Request Form.

5 – Quality Management and Privacy Rules

Access to Member Records

As needed for utilization management, quality assurance, and member grievance/appeal investigations, a provider may be requested to submit copies of a member's medical records. As stated in Participating Provider Agreement, records must be submitted within 10 business days of the request. Refusal to comply is could lead to immediate termination from the Linkia network.

Confidentiality and Accuracy of Health Records

For any medical records or other health and enrollment information provider maintains, Providers must:

- Safeguard privacy of any information that identifies a particular payer's member. Information from, or copies of, records may be released only to authorized individuals, and the Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or State laws, court orders, or subpoenas.
-
- Maintain records and information in an accurate and timely manner
- Ensure timely access by members to the records and information that pertain to them.
- Abide by all Federal and State laws regarding confidentiality and disclosure for medical records or other health information.

Use and Disclosure of Protected Health Information

Under the Privacy Rule, Linkia network Providers are prohibited from using or disclosing Protected Health Information of Linkia's contracted payer's members without their authorization, unless such use or disclosure falls within an exception. There are numerous use and disclosure exceptions set forth in the Privacy Rule. For example, one exception permits the use and/or disclosure of PHI without a member's authorization to carry out payment or health care operations (e.g., quality assurance, utilization review, credentialing, etc.). In addition, the use or disclosure of PHI without authorization is permitted for other specified purposes (e.g., public health activities, required by law, etc.). However, the member's authorization is required for most other uses and disclosures.

The Privacy Rule also requires that when we use, disclose, or request Protected Health Information, we must make reasonable efforts to limit the information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request. However, this minimum necessary standard does not apply to disclosures to, or requests by, health care providers for treatment purposes.

Access by Regulatory Agencies and Accrediting Authorities

During the term of the Provider Participation Agreement and for ten (10) years following its termination, or for such longer period required by applicable law, Provider shall give authorized representatives of Federal and State regulatory agencies and/or accrediting authorities, upon request, access to all books and records relating to the provision of O&P Services to Members for inspection and copying. Provider shall provide copies of any records requested by a Federal or State regulatory agency or an accrediting authority within ten (10) days of Provider's receipt of such request, free of charge.

Confidentiality of Linkia Proprietary Information

Provider agrees to keep strictly confidential and not to disclose, directly or indirectly, to any third parties any and all business, financial, enrollment, credentialing, utilization management, quality assurance, and risk management protocols and procedures or manuals, and/or any other information marked or otherwise designated "Confidential" or "Proprietary" and made available to Provider by Linkia and/or Payer Confidential Information. Upon request by Linkia and/or Payer or in the event of the termination of the Provider Agreement, Provider shall promptly return all such Confidential Information to Linkia or Payer, as the case may be. Provider agrees not to use any such Confidential Information of Linkia and/or Payer except for the purposes of performing Provider's obligations under the Provider Agreement.

Compliance Training

Beginning January 1, 2019, CMS no longer required health care providers participating in Medicare Advantage Part A and B Plans to complete CMS issued General Compliance, Fraud Waste and Abuse Training. However, Plan Sponsors can still include compliance training requirement in their provider contracts. As a First Tier Downstream and Related Entity (FDR) of a Medicare Advantage Plan Sponsor, Linkia will continue to require it's contracted providers and their employees complete CMS Annual Compliance and Fraud Waste and Abuse Trainings.

Linkia's contracted providers are required to complete CMS General Compliance and Fraud, Waste and Abuse (FWA) training within 90 days of network participation and upon hire of new employee(s) on an annual basis.

Each contracted provider must be able to demonstrate compliance with CMS requirements as stated in the Medicare Managed Care Manual Chapter 21 accessible through this link:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

A certificate of completion should be sent to Linkia within 7 business days of receipt at RCMBilling@Hanger.com with the words CMS Compliance Training Certificate in the Subject Line.

Consequences for not completing the CMS general compliance training could include correction action planning, or potential network termination. The correction action plan may include:

- Audit schedules, including start and end dates
- Announced or unannounced audits
- Necessary resources
- Types of Audit: desk or onsite
- Person(s) responsible
- Final audit report due date to compliance officer
- Follow up activities from findings

Sponsors must include in their work plans a process for responding to all monitoring and auditing results and for conducting follow-up reviews of areas found to be non-compliant to determine if the implemented corrective actions have fully addressed the underlying problems.

Corrective action and follow-up should be led or overseen by the compliance officer and assisted, if desired, by the compliance department staff, and include actions such as reporting findings to CMS or to the NBI MEDICs, if necessary.

Fraud and Abuse

Linkia providers are subject to all state and federal laws and regulations related to Fraud, Waste and Abuse (FWA). Provider must comply with Linkia, payer, CMS and any state or federal agency when identifying and investigation suspected fraud and abuse.

Linkia Attestation

Linkia providers must submit **annual attestation** attesting to the completion of the CMS General Compliance and Fraud, Waste and Abuse (FWA) training for all employees (including temporary employees, volunteers and others action as part of the workforce) and contractors involved in providing service under the Linkia, LLC. Provider Agreement. Linkia will give each provider at least 30 days to complete the validation and submit back to Linkia. Failure to complete the attestation by the end of each year could result in corrective plan up to and including termination from the Linkia network.

Annual Compliance Training Audit

As a First Tier Downstream Entity (FDR) for Medicare Advantage plans, we are required to validate that the training is complete. Linkia will select random offices for audit.

For the purposes of this audit, positions that need to be included but not limited to the following:

- Individuals who have direct contact with Medicare patients (clinicians, administrative staff)
- Individuals who access Medicare patients' PHI (billers, collectors, appeals specialists, technicians)
- Individuals with responsibility for signing or managing contracts with MAOs (managers, owners)

It is not necessary to provide training to or to report individuals such as custodial staff, maintenance workers or others who have no direct patient contact or who do not access PHI.

6 – Provider Complaint

A provider complaint is a written expression of dissatisfaction with Linkia, LLC regarding—but not limited to—payment delay, contract dispute, and customer service that does not mean claim status, payment dispute or routine provider inquiries. Providers must submit their complaint to Linkia using the Linkia Provider Complaint Form.

Upon receipt of provider compliant, Linkia will send a written acknowledgement to the provider within seven (7) business days. Once the complaint is addressed, Linkia will send written notification of resolution to the provider within thirty (30) calendar days of receipt of initial complaint.

Complaints are reviewed to determine whether investigation is required. When no investigation is required, the complaint is maintained in our records for tracking and trending purposes.

When an investigation is required, Linkia will launch an investigation to determine the cause of the complaint. Investigation could include, but not limited to, the following:

1. The nature and details of the complaint
2. The dates and results of the investigation
3. Review of processes, workflows, internal systems, and appropriate documents
4. Any corrective action taken
5. Reply to the complainant

Further consideration of the closed provider complaint will require a new request by the provider.

Corrective Action Plan

The purposes of a corrective action plan are to remove and/or minimize barriers, and to improve processes and customer service.

When applicable, a corrective action plan will be implemented to assist with minimizing barriers and to approve customer service and provider relations through the following:

1. Describing what caused the area of deficiency, how it occurred and frequency.
2. The tasks and/or steps taken to improve deficiencies, the person responsible for the responding to the corrective action plan, and the completion date.
3. Determine the expected outcome.

Linkia supports the quality standard for complaint management as defined by ABC/BOC here:

https://www.abcop.org/facility-accreditation/patientcare/Documents/Patient%20Care%20Facility%20Accreditation%20Guide.pdf

7 – Patient Complaint

A formal expression of dissatisfaction by a patient or designee made orally or in writing, with a specific outcome or resolution expect or any adverse health outcome resulting from a clinical event that may involve an O&P office, practitioner, or a fabricating laboratory, or any event in which a patient or designee states dissatisfaction with a patient care site and the patient's health status is not jeopardized.

Upon receipt of a patient complaint, Provider will document complaint in accordance with their internal Standard Operating Procedures (SOP). Provider follows timeframe requirements in aligned with internal SOP requirements. Provider must submit complaints to Linkia via the Linkia complaint from within 15 business days of resolution.

Complaints are reviewed to determine whether investigation is required. When no investigation is required, the complaint is maintained in our records for tracking and trending purposes.

When an investigation is required, Linkia will launch an investigation to determine the cause of the complaint. Investigation could include, but not limited to, the following:

1. The nature and details of the complaint
2. The dates and results of the investigation
3. Review of processes, workflows, internal systems, and appropriate documents
4. Any corrective action taken
5. Reply to the complainant

Further consideration of the closed provider complaint will require a new request by the provider.

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The purposes of a corrective action plan are to remove and/or minimize barriers, and to improve processes and customer service.

When applicable, a corrective action plan will be implemented to assist with minimizing barriers and to approve customer service and provider relations through the following:

1. Describing what caused the area of deficiency, how it occurred and frequency.
2. The tasks and/or steps taken to improve deficiencies, the person responsible for the responding to the corrective action plan, and the completion date.
3. Determine the expected outcome.

8 – Member Grievances/Complaint

A grievance is a written or verbal expression of dissatisfaction regarding but not limited to, quality of care concerns and/or customer service. If Linkia receives a complaint from a member or payer, a complete investigation will be launched within 48 hours. Providers are to promptly cooperate with all requests for information related to the complaint. All complaints are to be resolved within the established timeframe.

Upon receipt of a patient complaint, providers must document the complaint in accordance with their internal Standard Operation Procedures (SOP). Linkia reserves the right to request documents related to a patient grievance/complaint.
Clinical complaints will be review by Linkia's internal committee.

9 – Provider Communication

Linkia keeps providers updated on payer news, process changes, and new resources through a variety of communication outlets. Our provider communications are primarily sent via email or fax.

Alerts

As needed, alerts containing reimbursement and operational changes, as well as administrative updates are sent to contracted providers via e-mail. In cases where e-mail is not available the publication is sent via fax or mail.

Training

Provider training sessions are conducted periodically throughout the year. The training topics will vary, but at least one training will include information on compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements. Participation in the HIPAA training is required of at least one employee of each contracted provider organization.

10 – Provider Termination/Appeal

Reference Section 5.1. Term. This Agreement shall commence as of the Effective Date. The initial term of this Agreement shall be for one (1) year, and shall automatically renew for successive one (1) year renewal terms, unless otherwise terminated as provided herein.

Section 5.2. Termination without cause. Either party may terminate this Agreement at any time without cause by giving ninety (90) days prior written notice of termination to the other party.

5.5 – Continuation of Care after Termination – for details around the termination process and requirements to meet the needs of patients in care.

A provider or their representative, including legal counsel must submit a dispute/appeal of Linkia termination by sending a letter on company letterhead within 30 days of the notification to include the basis for appeal, within 5 (five) days of receipt of Linkia's termination notice. If the first level denial is upheld then a second level appeal is available and must be addressed within 15 calendar days of the notification.

The letter should be addressed to Linkia's Director of Regional Accounts, as follows:

Hanger Inc.
c/o Linkia LLC.
10910 Domain Drive #300
Austin, TX 78758
Phone: (877) 754-6542
Fax: (512) 201-6060
Email: RCMBilling@Hanger.com

11 – General Compliance

Provider must cooperate with and comply with ALL terms of Linkia Provider Participation Agreement. This includes all Linkia policies and procedures, including but not limited to those related to quality assurance, accreditation, utilization management, risk management and credentialing/re-credentialing. Providers are to comply with any updates they receive as noted in the agreement.

Provider must agree not to discriminate or differentiate in the treatment of any individual based on sex, marital status, age, race, color, religion, health status, disability, national origin, ancestry, sexual orientation, utilization or receipt of health care, genetic information, source of payment or evidence of insurability, including conditions arising out of domestic violence.

Upon request, Provider shall provide copies of Members' clinical records to LINKIA and/or a Payer for the purposes of utilization management, quality assurance, risk management, Member grievances or appeals, and/or benefits determination or payment. In addition, during the term of this Agreement and for ten (10) years following its termination, or for such longer period required by applicable law, Provider shall maintain and give LINKIA and/or Payer, or their respective designees, upon request, access to all books and records relating to the provision of O&P Services to Members for inspection and copying. Provider shall provide copies of any records requested by LINKIA, Member and/or Payer within ten (10) days of Provider's receipt of such request, free of charge.

Linkia reports instances of non-compliance to affected payers per their individual provider manual requirements. Such instances can lead to a corrective action plan and/or termination from the Linkia network.

12 – Medicare/Medicaid Requirements

This section is an overview of responsibilities for which Linkia, LLC and ALL participating providers, who service Medicare and/or Medicaid, members are accountable.

Participating Linkia, LLC providers:

- No Provider Agreement or subcontract can terminate the legal responsibilities of Linkia, LLC to Payer to assure that all the activities under this Contract will be carried out.
- All Affiliated Providers providing Covered Services for Linkia, LLC contracted

Managed Care Organization (MCO) Medicare and/or Medicaid networks must be enrolled as Providers in the Medicare and/or Medicaid program. Linkia, LLC shall not contract or subcontract with an Excluded Person or a Person who has voluntarily withdrawn from the Medicare and/or Medicaid program as the result of a settlement agreement.

- As it relates to MCO Medicaid and/or Medicare members, neither Linkia, LLC nor the Provider has the right to terminate the contract without cause and shall require the Provider to provide at least 60 days' notice to Linkia, LLC and assist with transitioning
  Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by Linkia, LLC or Enrollee.
- Prior to entering into a Provider agreement or subcontract, Provider shall submit a disclosure statement to Linkia, LLC specifying any Provider agreement or subcontract and Providers or subcontractors in which any of the following have a five percent (5%) or more financial interest:
  - Any Person also having a five percent (5%) or more financial interest in Linkia, LLC or its Affiliates as defined by 42 C.F.R. 455.101;
  - Any director, officer, trustee, partner or employee of Linkia, LLC or its Affiliates; or
  - Any member of the immediate family of any Person designated above.

- Provider shall not abandon any Member receiving treatment from Provider, or refuse to provide services to a Member because the Member has an outstanding debt with the Provider from a time prior to the Member becoming a MCO Member.

- Linkia providers must submit annual attestation attesting to the completion of the CMS General Compliance and Fraud, Waste and Abuse (FWA) training for all employees (including temporary employees, volunteers and others action as part of the workforce) and contractors involved in providing service under the Linkia LLC. Provider Agreement. Linkia will give each provider at least 30 days to complete the validation and submit back to Linkia. Failure to complete the attestation could result in corrective plan up to and including termination from the Linkia network.

Linkia, LLC:

- All Affiliated Providers shall be furnished with information about Linkia, LLC's Grievance and Appeal procedures at the time the Provider enters into an agreement with Linkia, LLC and within fifteen (15) days following any substantive change to such procedures.

13 – Contact Us

If you have any questions about your participation in the Linkia network, please contact us at:

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