



Imperial Insurance Companies, Inc.

and

Imperial Health Plan of the Southwest, Inc.

Exchange/Health Insurance Marketplace

Provider Manual 2025



Imperial Insurance Companies, Inc. and Imperial Health Plan of the Southwest, Inc. **Provider Manual 2024**

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SECTION 1. INTRODUCTION

1.1 Imperial Insurance Companies, Inc., and Imperial Health Plan of the Southwest, Inc.

Imperial Insurance Companies, Inc., (“IIC”) is a health maintenance organization licensed in the State of Texas in compliance with the Texas Insurance Code. IIC includes a number of counties in its approved service area where enrolled members may receive medical, dental and vision care from a robust contracted provider network. In addition to Texas, IIC is licensed in Arizona, New Mexico, and Nevada to provide HMO covered services. Imperial Health Plan of the Southwest, Inc., (“IHPSW”) is licensed as a health maintenance organization in Utah in compliance with the Utah Insurance Code. IIC was approved to provide health care services to enrolled-eligible members under the Patient Protection and Affordable Care Act (i.e., the “exchange,” “ACA,” or “marketplace”) in several counties in Texas, Arizona, and Nevada. In addition, IHPSW was approved to provide medical, dental and vision care services to enrolled-eligible members under the ACA in several counties in Utah.

IIC and IHPSW are both overseen by the same Board of Directors, Chief Medical Officer, and a Quality Management Committee and the other committees that oversee the care provided to IIC’s and IHPSW’s members.

1.2 Quality Management Committee

The Quality Management Committee is central to our business and oversees Utilization Management (UM) and Quality Management (QM) functions.

UM staff is familiar with pre-authorization processes required by Imperial’s current policy and procedure. Imperial’s policy is to expedite Urgent referral requests from providers by processing them within 72 hours. Standard requests are processed in 14 days. UM responsibilities include:

- Implementation of UM Program and Work Plan.
- UM reporting required for Imperial.
- Preparation for and participation in Imperial UM audits.
- Hospital Case Management.
- After-hours triage; and
- Other services as required by Imperial regulatory agencies, and the National Committee for Quality Assurance (NCQA).

QM staff monitors the quality of care provided by Imperial providers and conducts quality assessment studies. QM responsibilities include:

- Implementation of QM Program and Work Plan;
- Practice pattern profiling and analysis;
- QM studies and reports required by Imperial;
- Preparation for and participation in Imperial QM audits;
- Member complaints and grievances resolution;
- Clinical provider complaints and grievances;
- Credentialing and re-credentialing process; and
- Other services as required by Imperial, regulatory agencies, and the NCQA.

1.3 Provider Network Management

Provider Network Management (PNM) is committed to being accessible to all contracted providers daily. Representatives are responsible for answering providers' questions, addressing their concerns, and assisting with a resolution.

PNM shall collaborate with contracted providers to ensure all providers have the necessary information, resources, and assistance to work with Imperial. PNM responsibilities include:

- Provider Orientation to cover operations for Customer Service, UM, Claims, Eligibility, Imperial rosters, Websites, and QM.
- Provider Manual distribution.
- Issue resolution involving authorizations, claims, eligibility, capitation, and contracting.
- Provider education and training.
- Network updates.
- Distribution of health education material.
- Member enrollment issues.
- Provider complaints and assistance with grievances.

The PNM department is available Monday through Friday from 8:00 a.m. to 5:00 p.m. (PST). Our contact information is as follows:

- Phone: (800) 595-0619
- Email: pnm@imperialhealthholdings.com

1.4 Credentialing

The Credentialing Department maintains provider credentialing files in compliance with standards recognized and mandated by the NCQA, Imperial, and other accrediting agencies.

1.5 Enrollment and Eligibility

The Enrollment and Eligibility Department processes eligibility lists (electronic or paper) for Imperial, prepares and mails eligibility lists to Primary Care Providers (PCPs), and administers and reconciles eligibility.

1.6 Claims and Encounter Data Processing

The Claims and Encounter Data Processing Department adjudicates, reviews, analyzes, and pays claims, compiles claims timeliness reporting, participates in claims audits, and processes encounter data for Imperial reports.

SECTION 2. IMPORTANT CONTACT NUMBERS

2.1 Imperial Contact Numbers

Main Number	(800) 595-0619
Main Fax	(626) 521-6028
Eligibility Department	(800) 595-0619

UM Phone	(800) 595-0619 (626) 838-5100
UM Fax	(626) 283-5021 Outpatient Fax (888) 901-2526 Inpatient Fax
Case Management	(800) 595-0619 (626) 838-5100
Claims Department	(800) 595-0619
Claims Forwarding Address	AZ: PO Box 60567 Pasadena, CA 91116 TX: PO Box 61300 Pasadena, CA 91116 NV: PO Box 60590 Pasadena, CA 91116 UT: PO Box 60190 Pasadena, CA. 91116
Claims Payer ID (Electronic Submission)	AZ: IEXAX TX: IEXTX NV: IEXNV UT: IEXUT
Contracting/Provider Services	(800) 595-0619
Contracting/Provider Service Fax	(214) 452-1190

SECTION 3. RESPONSIBILITIES OF IMPERIAL'S CONTRACTED PROVIDERS

3.1 Medical Services Covered under Primary Care

The following services are covered under PCP services unless special prior arrangements have been made with Imperial. Please refer to your Provider Agreement with Imperial for more information regarding coverage provisions. Covered medical services include all services a PCP customarily makes available to patients of his or her own practice, including but not limited to the services listed below:

- Maintain office accessibility to members during normal business hours (8:00 am to 5:00 p.m.) Monday through Friday, exclusive of federal holidays.
- PCPs are required to arrange for and provide 24/7 on-call coverage for all enrolled managed care members unless previous arrangements have been made with Imperial.
- First point of contact care for persons with previously undifferentiated health concerns.
- Office visits and examinations (diagnosis treatment of illness and injury).
- Adult and Pediatric health maintenance.
- Periodic health appraisal examination, including all routine tests performed in PCP's office.
- Routine gynecological examinations including pap smears.
- Venipuncture and administration of injections and injectables.
- Minor office surgical procedures, including repair of simple lacerations to areas other than the face, ear lavage, I&D of superficial soft tissue abscess, EKG, visual acuity testing, trigger point injections, arthrocentesis, etc.
- Specimen collection.
- Nutritional counseling.
- Interpretation of laboratory results.
- Telephone consultations.
- Coordination of other health care services as they relate to member care.
- Immunizations, for adults and children, in accordance with accepted medical practice in the community; and
- Health education in disease prevention, exercise, and healthy living practices.

3.2 Role of Specialty Care Physicians

Specialty care physicians (specialists) provide referral services, consistent with industry standard medical practices, to Imperial members upon request by the PCP with authorization from Imperial. Specialists are responsible for communicating results and findings back to referring PCPs for continuity and/or coordination of care. Specialists are responsible for the following:

- Provide medically necessary specialty care authorized by Imperial.
- Work in conjunction with PCPs to assure continuity of patient care.
- Make authorization requests through referring PCPs.
- Submit treatment plans to PCPs and Imperial for continued specialty care.
- Assist PCPs and Imperial in coordinating ancillary services and hospitalization.
- Arrange for practice coverage by another Imperial contracted/participating physician for periods of unavailability (e.g., vacation, jury duty, holidays, illness, etc.);
- Provide and arrange for 24/7 on-call coverage for all managed care members; and
- Participate in respective UM/QM committees and programs as may be required under contract.

NOTE:

Specialists can only submit referral authorization requests, through the PCP, for additional continued care or treatment of members and cannot refer members to other specialists. Unauthorized services will not be reimbursed. Specialists must notify Imperial to arrange for a Memorandum of Understanding to be in place when a non-participating provider is scheduled to take calls for the specialist or assist the specialist with a service or procedure. The use of a call answering machine is not an acceptable form of on-call coverage.

3.3 Appointments and Services

The following are standards and requirements for appointments and services rendered by PCPs as required by Imperial, CMS, and/or other regulatory agencies, including State Health and Human Services (HHS).

Type of Appointment and Services	Access Standards and Requirements
PCP Availability	<ul style="list-style-type: none"> • PCP must be available by telephone 24/7. • If the PCP is unable to provide on-call services, arrangements must be in place to cover the PCP after hours and on weekends; covering physician must be credentialed by Imperial.
Appointment Scheduling Systems	<ul style="list-style-type: none"> • Providers should use an efficient and effective written or computerized appointment scheduling system, which includes follow-up on canceled appointments.
In-Office Waiting Time	<ul style="list-style-type: none"> • The waiting time for scheduled appointments should be reasonable and within community standards.
Appointments for Urgent and Routine Primary Care Services	<ul style="list-style-type: none"> • For urgent primary care services, PCPs are required to triage and provide same-day appointments for members. • For routine primary care services, the maximum timeline for appointments is as follows: <ol style="list-style-type: none"> 1. Physical exams and routine preventive services: 4 work weeks. 2. Routine ambulatory visits: 7 business days.
Appointments for Routine Physician Consultations and Specialty Referrals	<ul style="list-style-type: none"> • Specialists must schedule an appointment for non-urgent, properly authorized referrals within 15 calendar days.
Appointments for Routine Prenatal Care	<ul style="list-style-type: none"> • Members in their first or second trimester: initial appointments must be available within one week from the date of the member's request. • Members in their third trimester and/or identified as "high risk": initial appointments must be made within 3 days of the member's request.
90-day Initial Health Assessment (IHA)	<ul style="list-style-type: none"> • Each newly enrolled member is expected to receive an IHA within 90 days of enrollment.

Type of Appointment and Services	Access Standards and Requirements
Appointment for Sensitive Services	<ul style="list-style-type: none"> • Sensitive services must be made available to members within two days of the member’s request for appointment. Sensitive services include services related to mental or behavior health, sexual and reproductive health, sexually transmitted infections, substance abuse, gender-affirming care, and intimate partner violence. • Sensitive services will be provided under the following conditions: <ol style="list-style-type: none"> 1. For minors 12 years of age and older: without necessity of preauthorization, referral, or parental consent. 2. For all members: confidentially, in a manner that respects the member’s privacy and dignity.

3.4 Telephone Access

PCPs, specialists, or office staff must return any non-urgent phone calls to members within 24 hours. Urgent and emergent calls are to be handled by the PCP according to Federal Regulations or State HHS standards, 24/7, unless prior arrangements have been made with Imperial.

3.5 Services for Members with Disabilities

PCPs and specialists must comply with all provisions of the Americans with Disabilities Act (ADA), including a handicapped bathroom or alternative access equipped with handrails, a handicapped access ramp, a handicapped water fountain or alternative provisions, an elevator (when applicable), and at least one handicapped parking space.

TDD/TTY Access for the Hearing Impaired is 711.

3.6 Interpreter Services

- PCPs and specialists are required to offer interpreter services to members with Limited English Proficiency (LEP) to provide quality health care services.
- Members should not be asked to use their own interpreters or to use family, friends, or minors to interpret.
- If a member declines interpreter services, the provider must note this in the member’s medical record.
- Imperial providers must provide interpreter services 24/7 through IIC’s AT&T or other contracted language lines. Providers can access language lines if requested by the member in his/her language. After-hours phone services staff should be instructed on how to connect with the language line.
- If a patient has LEP and requires language assistance, contact (800)-708-5976 (TTY 711)
- See section 9.2 for additional information on the Language Assistance Program and Culturally and Linguistically Appropriate Services requirements.

3.7 Credentialing and Facility Site Review

Imperial contracted providers must be credentialed in accordance with guidelines set forth in Imperial’s credentialing policies and procedures and as required by other applicable regulatory agencies or accrediting bodies. Acceptance of a provider into Imperial is contingent upon successful completion of the credentialing process.

pass facility site reviews conducted by Imperial. Continued participation with Imperial is dependent upon successful completion of the re-credentialing process that takes place every three (3) years.

The following documents are required for the initial credentialing process:

- CAQH Number
- Pay to W-9;
- State Credentialing Release; and
- Supervisor Agreement (Medical Doctors only).

In addition, the following criteria are incorporated into the re-credentialing process:

- Member complaints;
- Information from quality improvement activities; and
- Member satisfaction.

A. Provider Status Change

State HHS departments and CMS mandate that members be notified of any provider status change 30 days prior to the change, or in cases of emergency, within 14 days of the change.

Any planned change in status, such as an address or phone number change, malpractice insurance coverage, or staffing changes must be reported immediately to Imperial.

B. Required Reporting

If any of the following events occur, Imperial must file with the State medical board (or other relevant state licensing agency) and report to the National Practitioner Data Bank (NPDB) within 15 calendar days after the effective date of the action:

- The applicant's application for Imperial participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason;
- The provider's participation status is terminated or revoked for a medical disciplinary cause or reason;
- Restrictions are imposed or voluntarily accepted for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason;
- The provider resigns or takes a leave of absence from Imperial; or
- Imperial participation status changes following notice of any impending investigation based on information indicating medical disciplinary cause or reason.

Imperial must notify the provider in writing of any adverse action taken. A contracted provider may request a fair hearing if there has been a reduction, termination, or suspension of the provider's contractual relationship.

C. Providers Rights

As a provider you have the following rights:

- Review the information submitted to support your credentialing application.
- Correct erroneous information from other sources.
- Receive status of your credentialing or re-credentialing application upon request.

3.8 Hospital Admissions and Admitting Staff

A contracted PCPs must have admitting privileges with a contracted-network hospitals that is geographically close to the office where the PCP practices medical care. The Admitting Team should always be notified by PCPs for assistance and coordination of care whenever an Imperial member is admitted. The Imperial Chief Medical Officer, or his or her designee, must be promptly notified (i.e. within 24 hours of admission) when an Imperial member is admitted to an acute care facility so that he (or she) can provide follow-up care.

3.9 Medical Records

PCPs are responsible for maintaining a legible, detailed, confidentially stored, easily retrievable medical record for each patient for ten (10) years, as required and mandated by CMS. Patient medical records are confidential documents used by release of medical information and records will be in accordance with Federal, State, and local statutes.

A. Confidentiality

Medical records will be stored in an area of medical practice with access limited to authorized staff only. All staff members must sign a Confidentiality Statement assuring that access to medical records and the information therein is confidential, and that this information may not be released without permission, nor can it be sold in total or in part.

All patient information is confidential and must be protected from disclosure to unauthorized personnel in accordance with the Federal HIPAA Act of 1996 regulations and applicable State laws. Patient information includes the patient's name, address, telephone number, social security number, or CHP or STAR identification number.

B. Standard Requirements

The following requirements apply to ALL Medical Records:

- A separate medical record is maintained for each patient;
- The medical record is to be stored in a secured place;
- Each medical record will contain at a minimum:
 - Complete patient name
 - Date of birth
 - Gender
 - Marital Status
 - Home address and phone number
 - Employer address and phone number (if applicable)
 - Insurance and member identification number
 - Signature on file for consent to treatment
 - Member's Primary Language;
- All pages in the medical record must contain the patient's name or identification number;
- All entries are dated and signed by the author (full signature and title are required);
- All entries must be dated and signed or initialed by the provider; and
- The medical record must be legible to others besides the provider and their staff.

C. Notation Requirements

A notation must be made in the medical record for each visit and must include:

- The date of the visit;
- The patient's chief complaint;
- A documented physical exam relevant to the complaint;
- A diagnosis and/or impression;
- A medication list that includes medication history and current medications;
- Medication allergies, adverse reactions, or the absence of known allergies, noted in a consistent fashion;
- A problem list that includes medical conditions and significant illnesses and surgeries;
- A comprehensive health history (for patients seen three or more times).

For children and adolescents under 18 years old, the history includes:

- Prenatal and perinatal care;
- Childhood illnesses; and
- Surgeries.

For patients over 14 years old, use of tobacco, alcohol, and substance abuse are documented for patients seen more than three times.

Progress notes must document the following:

- Height, weight, and vital signs;
 - The patient's chief complaint;
 - Unresolved problems from previous visits;
 - A physical exam consistent with the chief complaint; and
 - A working diagnosis;
- Tests, referrals, consults, and a plan of treatment consistent with working diagnosis;
 - Prescribed medications include name of drug, dosage, and administration frequency, and duration;
 - Follow up plan and date of return visit or PRN; and
 - Health education and preventative care.
- Telephone advice is documented
 - The physician initials and dates consultant summaries, laboratory, and other diagnostic reports. Consultant summaries and abnormal lab and diagnostic test results have a chart entry including a follow up care plan
 - Immunization records appropriate to age are initiated on all patients
 - Preventive screening and health education services are offered
 - Problems lists are updated with each visit and unresolved problems are addressed at the next visit.
 - Missed appointments are to be documented in the medical record. At a minimum, three attempts will be made to determine the cause of the missed appointment.
 - Documentation includes a notation of the time and method used to contact the member
 - Refusal to have a translator outside of family and or friend must be documented
 - Any access to care problems is to be documented in the medical record

3.10 Vaccine and Immunization Administration

Vaccines for Commercial HMO members shall be the PCP's sole responsibility. Please refer to the PCP Agreement for reimbursement information.

Provider Notice for Termination of Patient Services

A CMS-approved provider can terminate a patient's services by providing written notice. The notice must include the reason for termination, the effective date, and how to get continued care.

Provider notice requirements

- Provide a written notice by certified mail with return receipt requested
- Include the reason for termination and the effective date
- Offer emergency care before the effective date
- Offer referrals for continued care
- Specify that the patient is responsible for follow-up care

Patient appeal

If a patient appeals the termination, the plan must provide a detailed explanation.

Reasons for termination

A provider can terminate a patient relationship for valid reasons, such as: non-compliance, inappropriate behavior, communication breakdowns, non-payment, and other issues that impede care.

SECTION 4. DATA AND CLAIMS SUBMISSION

4.1 Claims Submission

Industry standards require that all claims be submitted within 60 calendar days, or as defined in your provider services agreement following the end of the month. Claims will be processed, and payments made in accordance with the Timeliness Guidelines promulgated pursuant to the CMS and State regulations. Claims should be submitted to Imperial for services performed by the physician according to the contract.

Imperial will only accept claims submitted on an industry standard CMS 1500 or UB04 Claim Form.

For Imperial to accurately adjudicate claims and ensure timely processing and payment for services rendered to IMPERIAL members, it is imperative that all information required on the CMS 1500 & UB04 is provided. Imperial will review all claims submitted to ensure that the billed level of care is consistent with the level of care authorized by Imperial and/or the service level of care provided with proper documentation. In the event a higher level of care is billed, Imperial will pay based on the authorized level of care.

The following minimum information must be on all CMS 1500 & UB04 claims to be considered a “clean claim,” otherwise the claim may be pending or denied:

- Patient's name and date of birth;
- Patient's insurance identification number;
- Patient's complete address;
- Date of onset of illness or injury (or last menstrual period where applicable);
- ICD-10 diagnosis code(s) and procedure and modifier code(s) (CPT or HCPCS);

- Referring physician;
- Date(s) of service, place of service, type of service, quantity/unit of service(s), and normal charges;
- Authorization number in Box 23 (when required);
- The Physician's Federal Tax ID number, NPI number (where applicable);
- Name and address of facility where services were rendered;
- Name, address, zip code, and phone number of Physician submitter;
- Attached OR, ER notes and medical reports for E&M codes billed as complex or severe;
- A copy of the authorized referral attached to the claim (when required); and
- EOB attached if other coverage (COB) applies.

All billable services and claims must be submitted on the respective CMS 1500 or UB-92 form for services rendered. Superbills are not acceptable as claims for reimbursable services (e.g., non-capitated services, etc.) Send ALL claims to the following addresses:

Imperial Insurance Companies, Inc.:

- **Arizona Exchange Claims Department**
P.O. Box 60567
Pasadena, CA 91116
• Electronic Office Ally Payor ID# **IEXAZ**
- **Texas Exchange Claims Department**
P.O. Box 61300
Pasadena, CA 91116
• Electronic Office Ally Payor ID# **IEXTX**
- **Nevada Exchange Claims Department**
P.O. Box 60590
Pasadena, CA 91116
• Electronic Office Ally Payor ID# **IEXNV**

Imperial Health Plan of the Southwest, Inc.:

- **Utah Exchange Claims Department**
P.O. Box 60190
Pasadena, CA 91116
• Electronic Office Ally Payor ID# **IEXUT**

Providers can sign up for the Office Ally website at www.officeally.com or by calling (866) 575-4120

***For all claim inquiries, please email: claimsinquiryex@imperialhealthholdings.com**

Please refer to the Compensation Fee Schedule within your Provider Agreement to determine the payment amount you will receive for services rendered. All payable claims shall be processed in accordance with the applicable fee schedules and guidelines promulgated by each State.

Special services that cannot be identified with the appropriate CPT or HCPCS codes shall undergo Imperial’s medical review and, if allowable, will be processed in accordance with the reimbursement rates generally provided in the community where care was provided.

SECTION 5. ENROLLMENT AND ELIGIBILITY

5.1 Eligibility Verification

Providers must verify patient eligibility before providing any service. Possession of a membership card DOES NOT guarantee eligibility.

- Providers are encouraged to check eligibility of members by calling Imperial directly.
- Always try to find the member's name on the most recent Imperial Eligibility List (E-List). The E-List can be accessed in the EZ-NET Provider Portal.

The Affordable Care Act mandates that all qualified health plans like Imperial offering coverage through the Health Insurance Marketplace provide a grace period of three consecutive months to APTC Members^[1] who fail to pay their monthly premium by the due date. Imperial offers a one-month grace period to non-APTC^[2] members.

Claims Processing:

First Month of Grace Period: Clean claims received for services rendered during the first month of a grace period will be processed using Imperial Insurance Companies, Inc.’s standard processes and in accordance with state and federal regulations and within established turn-around-times.

Second/Third Month of Grace Period: Clean claims received for services rendered during the second and third months of an APTC Member’s grace period will be pended until the member premium is paid in full. If the APTC Member is terminated for non-payment of the **full premium** at the end of the grace period, Imperial **will deny claims for services rendered in the second and third months of the grace period. If a member is termed for non-payment of premium, they will be responsible for the cost of health services they receive after their last day of coverage.**

Action requested:

Providers should check the eligibility and payment status of a member for service during the grace period. Please remind and encourage members to stay current on premium payments and to pay the full premium prior to the end of the grace period.

5.2 Eligibility List

Member eligibility is available on the provider portal at

<https://portal.imperialhealthholdings.com/EZ-NET60/login.aspx>

[1]

An APTC Member is a member who receives Advanced Premium Tax Credits (premium subsidy), which helps to offset the cost of monthly premiums for the member.

[2]

A Non-APTC Member is a member who is not receiving any Advanced Premium Tax Credits (APTC) and is therefore solely responsible for the payment of the full monthly premium amount.

5.3 Member Disenrollment

PCPs are encouraged to promptly establish a patient-physician relationship with all Imperial members to promote continuity of care and to address and promptly resolve any health care needs or concerns of the patient.

5.4 Provider Status Change

Any planned change in status—such as a change in address, phone number, malpractice insurance coverage, or staffing—must be reported immediately, and at least thirty (30) days prior to the change, to Imperial’s Credentialing Department.

SECTION 6. REFERRALS

6.1 Referral Authorization Process and Guideline

PCPs are responsible for obtaining an authorization when referring a patient for specialty services.

Specific Specialty physician services are covered only when properly authorized. PCPs should initiate authorization requests for the initial referral, and specialists should initiate authorization requests for follow-up services with the same specialist. If the patient requires a specialist-to-specialist referral (e.g., an orthopedist wants to refer a patient to a neurologist), the specialist may refer the patient directly to the new specialist and communicate the referral to the patient’s PCP. PCPs and specialists should use a provider within Imperial’s panel. Fax authorization request forms to:

Imperial Health Plan of the Southwest,
Inc.
Imperial Insurance Companies, Inc.
Attn: UM Department
Phone: (800) 708-8273
Fax: (626) 283-5021

In accordance with NCQA standards, Imperial’s UM staff and medical directors who make or supervise utilization related decisions base medical coverage decisions only on the clinical appropriateness of care and service.

Imperial does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. In addition, there are no financial incentives for Utilization Management decision makers, and Imperial does not encourage decisions that result in underutilization.

6.2 Referral Submission Process for Routine and Urgent Referrals

Use Imperial’s provider portal to submit online referrals. Please upload pertinent clinical documentation (e.g., progress notes, diagnostic test results, medications, and treatments for medical necessity reviews). For provider portal support and assistance, please contact (800) 595-0619 or email: Portal@imperialhealthholdings.com

General Referral Form in Section 14 can be used and may be faxed to
Imperial’s UM Department at (626) 283-5021.

The following information must be provided to avoid unnecessary delays:

- Member’s name;
- Member ID number;
- Specialist’s name;
- Reason for referral (provide all pertinent progress notes which may include diagnostic test results, medications or treatments tried);

- Number of visits requested; and
- CPT and ICD-10 codes.

6.3 Guidelines on Authorization Turn-Around Time

Urgent Request Definition: an “urgent request” is one in which the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, such that the *normal* timeframe for the decision-making process would be detrimental to the enrollee's life or health.

Type	Processing Timeframe	With Extensions*
Standard Pre-Service	14 Calendar Days	28 days (non-contracted only)
Standard Part B Drug	72 hours	N/A
Retrospective	30 Calendar days**	N/A
Urgent Pre-Service	72 Hours	17 days
Urgent Part B Drug	24 hours	N/A

6.4 Approved Referrals

Once a referral request is approved, Imperial’s UM Department will notify the PCP and Specialist via fax and send a letter to the patient/member. If the referral is an urgent request, the UM department will also notify the member by phone.

It remains the responsibility of the PCP's office to notify the patient once the referral has been approved. The PCP must ensure that the name, address, and phone number of the specialist are given to the patient.

The PCP must also track and record the member having kept the appointment with the specialist, date, and time.

6.5 Denied Referrals

Imperial’s UM Department will mail a letter to the patient and the provider informing them of any denial and providing information on the Appeal Process.

The UM department also sends a copy of the denial letter to the PCP, including the medical policy criterion for the denial. The PCP must file this letter in the member's medical record.

The referral may be denied for one of the following reasons:

- Member is not eligible with Imperial;
- Service requested is not a covered benefit;
- Service requested is the responsibility of the PCP;
- Medical necessity could not be established; or
- Service is carved-out to another entity.

Please Note: If the information provided on the referral form is not sufficient to determine medical necessity, a letter requesting additional information will be sent to the Requested Provider. The missing information may be:

- Lab or other diagnostic test results;
- Additional family or personal health history; or
- Consultation or progress notes from the PCP or Specialist.

Utilization criteria and guidelines are available upon request for the specific procedures or conditions requested.

6.6 Emergency Room Utilization, Urgent Care and Emergent Referrals

“Emergent” means a sudden injury or onset of illness that, if immediate care is not provided, may result in permanent damage or cause loss of life or limb to the patient.

If contacted by the Member, the PCP or his/her on call physician is responsible for determining the medical necessity of

an urgent care or emergency room (ER) visit. After hours, urgent care referrals should be directed to the contracted urgent care centers (listed on Provider Rosters):

An acute care facility, urgent care clinic or any emergency room cannot be used to provide primary care services in lieu of the PCP's office. The PCP may refer members to an ER when an emergency or urgent condition exists. The protocols for ER referrals and care coordination are as follows:

- The PCP is responsible for immediately responding to all calls from the ER.
- The patient will receive a medical screening exam (MSE) in the ER.
- If the PCP is notified of emergent patient care, the PCP should evaluate the situation and give specific orders to ER staff.
- If the patient can be treated and released with no further treatment, the patient should be released and instructed to follow up with the PCP, not the ER.
- If the patient requires additional treatment, the ER staff must contact the PCP.
- For an inpatient admission, the ER staff should obtain an authorization from the PCP. If the PCP does not have admitting privileges at the hospital, the PCP should call the admitting physician.

Procedure for Emergent Referrals:

1. Make sure the General Referral Form contains the following information: member's name, reason for referral, member ID number, number of visits requested, specialist's name, CPT and ICD-10 codes.
2. Fax a copy of the General Referral Form to Imperial's UM department at (866)-811-0455. Requests may also be phoned in.
3. The UM department will review eligibility, benefit coverage, and medical necessity.
4. The PCP and Specialist will receive a copy of the authorization, either by fax or electronically, within 72 hours if the authorization is approved, and within 48 hours if the authorization is denied or modified. Verbal authorizations may be given but need to be followed up in writing.

The acute care facility is responsible for notifying Imperial's UM Department via fax at (626) 283-5021 or phone at (800) 595-0619 of any ER visit or emergency inpatient admission on the business day following notification by the Member, ER, or admitting facility.

In the event the PCP is unaware of an inpatient admission, the UM department will notify the PCP upon discovery of the information.

SECTION 7. CASE MANAGEMENT PROGRAM

7.1 Case Management Referrals/Eligibility Criteria for Case Management Referrals

Imperial has established a CM program to provide a direct interface with its members and to work closely with its providers to coordinate care and services for high-risk members. CM's goal is to help members regain optimum health or improved functional capability, educate members regarding their chronic condition, and reinforce the PCP prescribed treatment plan.

Imperial utilizes two distinct processes to identify members for enrollment in CM, which include both administrative and electronic data as well as referral sources. The CM referral form is included in an appendix at the back of the Provider Manual.

7.2 Case Identification and Enrollment Criteria

CM prioritizes members based on risk and opportunity. The program aims to identify members with advanced illness (e.g., terminal illness) and chronic illness, as well as to identify opportunities to engage members in ways that will improve quality

of care and outcomes while reducing avoidable costs.

General program inclusion criteria include:

- Major organ transplant;
- Major trauma;
- Poly pharmacy consisting of more than 30 prescriptions per quarter;
- Two or more admissions within a 12-month period;
- Re-admission within 30 days with the same or similar diagnosis or condition; and
- Cancer diagnosis requiring multiple treatment modalities with care coordination across multiple disciplines.

SECTION 8 NON -COVERED PROGRAM SERVICES

8.1 Non-Covered Services

Check with each individual Plan Program's Summary of Covered Benefits and Evidence of Coverage to determine if services are covered.

SECTION 9. LINKED AND CARVED OUT SERVICES

Below are some of the examples of services that are linked or carved out of 'members' health plan benefits.

- Pediatric Dental
- Pediatric Vision
- Pharmacy

SECTION 10. COMPLAINTS AND GRIEVANCES

10.1 Member Complaints and Grievances

The complaint and grievance process applies when a member files a complaint that does not involve a determination of coverage. Grievances may be filed for issues regarding quality of care, termination, adequacy of facilities, waiting times, or interpersonal problems with providers. Please keep the following in mind:

- Members must be informed of their right to complain and may submit complaints orally or in writing to Imperial.
- Members should be directed to call Imperial's Member Services Department to file a grievance.
- Members can obtain a complaint form, either from their provider's office or Imperial's website, www.imperialhealthplan.com.
- Imperial is required to acknowledge a member's complaint and resolve the member's complaint within thirty (30) calendar days.
- Members can call Imperial, CMS, and/or the state HHS department if the complaint is not resolved to their satisfaction.
- Providers are expected to respond to grievance resolution requests in a timely manner, typically within two business days. Providers are expected to provide a complete response to all issues raised, including any requested records.
- Providers may not terminate members for filing a complaint.

Common reasons for grievances include:

- Length of time required to see a provide or schedule appointments;
- Difficulty in obtaining a referral;
- Lack of courteous treatment on the part of a provider’s personnel;
- Crowded or cluttered waiting room conditions; and
- Member feels that the provider is not giving the member what he/she wants versus the provider determines is needed.

10.2 Claims Settlement & Grievance Practices

Imperial will process claim disputes under its Provider (Claim) Dispute Resolution Policy & Procedure guidelines. Disputes must be submitted in a written format that clearly documents and identifies the issue in dispute. (Refer to the following “Downstream Provider Notice” for full disclosure and instructions). Contracted provider claim disputes should not be sent to the Appeals and Grievances department.

Claims grievances for the Commercial Marketplace are processed under CMS and State regulatory guidelines and shall adhere to the timelines for receipt and response as promulgated.

10.3 Member and Provider Satisfaction Surveys

To measure the overall satisfaction of individual physicians and members, Imperial requests that providers participate in data collection regarding satisfaction.

Provider Satisfaction is recommended to be completed at least once per year.

Attached forms 14.3 and 14.4 are provided for the purpose of gaining information regarding satisfaction.

Form 14.4 is a Member Satisfaction form. Imperial requires that PCPs give these forms to members to complete. Members may complete the form and return it to the PCP or, if needed, office staff can assist the member in completion.

Form 14.3 is Provider Satisfaction Form. This form is for the PCP to complete. Both forms should be returned to Imperial by fax at the identified number at the bottom of the forms.

SECTION 11. COMPLIANCE

11.1 Code of Conduct and Business Ethics

The Code of Business Conduct is a critical component of a compliance plan. Imperial is committed to upholding the highest standards of integrity by following the Guiding Principles of Business Conduct, as follows:

- Equal Employment Opportunity
- Protection Against Harassment and Discrimination
- Americans with Disabilities Act
- A Drug-Free Workplace
- Workplace Violence Prevention
- Standards of Workplace Conduct Regarding:
 - Dealing with Customers
 - Conflicts of Interest

- Confidentiality
- Use of Company Resources
- Compliance with Laws and Regulations
- Dealing with Government Officials and Public Employees
- Dishonesty and Fraud

11.2 Compliance Program

Imperial's Compliance Program has the potential of enhancing the quality, productivity, and efficiency of our operations while significantly reducing the probability of improper conduct and legal liability, including but not limited to reducing fraud and abuse. Imperial's Compliance Program strives to improve operational quality by fulfilling four primary goals:

- 11.2.1 Articulate and demonstrate imperial insurance companies' commitment to regulatory compliance and legal and ethical conduct.
- 11.2.2 Increase the likelihood of preventing, identifying, and correcting non-compliant or illegal conduct;
- 11.2.3 Formulate and utilize internal controls to promote compliance with state and federal laws and regulations as well as organizational policies and procedures; and
- 11.2.4 Create an environment that encourages employees to recognize and resolve potential compliance problems.

All providers, including provider employees and provider subcontractors and their employees, are required to comply with Imperial's compliance program requirements. Imperial's compliance- related training requirements include Corporate Integrity, HIPAA Privacy and Security Training and Fraud, and Waste and Abuse (FWA) Training.

11.3 Fraud, Waste and Abuse Compliance

The purpose of Imperial's Fraud and Abuse Awareness and Detection Plan is to comply with state and federal laws and regulations, to identify and reduce costs to Imperial and its providers, subscribers, payers, and enrollees caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. Activities detailed in the anti-fraud plan include:

- 11.3.1 Protect health care consumers and particularly Imperial members, providers, and the health plan itself against potentially fraudulent activities.
- 11.3.2 Prevent fraudulent activity through deterrence.
- 11.3.3 Retrospective drug utilization review of controlled substances claims for possible fraud and/or abuse by specific indicators such as multiple prescriptions, multiple prescribers, etc.;
- 11.3.4 Detect fraud through existing mechanisms (such as claim fraud detection systems);
- 11.3.5 Comply with the requirements of Section 1348 (a through e) of the Knox Keene Act;
- 11.3.6 Provide a procedure for Imperial staff to follow if fraud is suspected; and
- 11.3.7 Notify the appropriate internal departments, company officers/Board of Directors and/or government agencies.

A hard copy of these policies and procedures is available to employees and other interested parties through Imperial's administrative offices. Participating providers must follow all CMS rules and regulations.

11.4 Privacy Practice Notice Guidelines

A. Background

Timely, accurate, and complete health information must be collected, maintained, and made available to members of an individual's healthcare team so that members of the team can accurately diagnose and care for that individual. Most consumers understand and have no objections to this use of their information.

Although consumers trust their caregivers to maintain the privacy of their health information, they are often skeptical about the security of their information when it is placed on computers or disclosed to others. Increasingly, consumers want to be informed about what information is collected, and to have some control over how their information is used.

B. Federal Requirements

Standards for Privacy of Individually Identifiable Health Information

In general, the federal Standards for Privacy of Individually Identifiable Health Information, also known as the HIPAA Privacy Rule.

Except for certain variations or exceptions for health plans and correctional facilities, an individual has a right to notice as to the uses and disclosures of protected health information that may be made by the covered entity, as well as the individual's rights, and the covered entity's legal duties with respect to protected health information.

In general, the content of the notice must contain:

1. A header: "THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.";
2. A description, including at least one example of the types of uses and disclosures that the covered entity is permitted to make for treatment, payment, and healthcare operations;
3. A description of each of the other purposes for which the covered entity is permitted or required to use or disclose protected health information without the individual's written consent or authorization;
4. A statement that other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization;
5. When applicable, separate statements that the covered entity may do the following: 1) contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual; 2) raise funds for the covered entity; and 3) that the group health plan or health insurance issuer or HMO may disclose protected health information to the sponsor of the plan;
6. A statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, including:
 - the right to request restrictions on certain uses and disclosures as provided by 45 CFR 164.522(a), including a statement that the covered entity is not required to agree to a requested restriction;
 - the right to receive confidential communications of protected health information as provided by 164.522(b), as applicable;
 - the right to inspect and copy protected health information as provided by 164.524;
 - the right to amend protected health information as provided in 164.526;
 - the right to receive an accounting of disclosures as provided in 164.528; and
 - the right to obtain a paper copy of the notice upon request as provided in 164.520;
7. A statement that the covered entity is required by law to maintain the privacy of protected health information and to provide individuals with a notice of its legal duties and privacy practices with respect to protected health information;
8. A statement that the covered entity is required to abide by the terms of the notice currently in effect;
9. A statement that the covered entity reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains;
10. A statement describing how it will provide individuals with a revised notice;
11. A statement that individuals may complain to the covered entity and to the Secretary of Health and Human Services if they believe their privacy rights have been violated; a brief description as to how one files a complaint with the covered entity; and a statement that the individual will not be retaliated against for filing a complaint;
12. The name or title and telephone number of a person or office to contact for further information; and
13. An effective date, which may not be earlier than the date on which the notice is printed or otherwise published.

SECTION 12. Quality Management Program

The mission of Imperial's QM program is to assure the delivery of quality patient care by providing and managing a coordinated, comprehensive, quality health care network in the service area, without discrimination based on health status, and in a culturally competent manner.

Imperial has not delegated QM. The QM program documents all the activities for which there is QM delegation.

Purpose

Imperial is committed to delivering high quality and affordable health care to its members. Dedicated physicians and office staff provide personal and individualized care with special sensitivity to cultural needs.

To assist the individual providers in meeting these commitments, the QM Program was developed to ensure compliance with local, state, federal, and national managed health care plan standards. Tools and guidelines provided by the health plans are incorporated to support these goals.

Scope

The scope of Imperial's QM program includes the entire spectrum of contracted providers, committee members, administrative staff, and enrolled members.

Aspects of internal administrative processes which are related to service and quality of care include credentialing, quality improvement, UM, member safety, complex case management, disease management, complaints, grievances and appeals, customer service, provider network, claims payment, and information systems.

The QM program addresses:

- Aspects of both medical care and service;
- Continuum of care issues;
- Reporting sentinel events to the health plan department, such as:
 - Admissions due to complications resulting from outpatient surgery or procedures;
 - Admissions within 48 hours after an emergency room visit;
 - Admissions within 30 days of a prior admission;
 - Admissions with a diagnosis of asthma;
 - Accident, injury, and falls during a stay at an acute or skilled nursing facility;
 - Decubiti;
 - All deaths;
 - Return to surgery as a result of a previous operation;
 - Infection after invasive procedure or surgery; and
 - Surgery on normal organ, body part or tissue;

- Member complaints, grievances, and appeals;
- Research and feedback from health plans;
- Provider availability and access;
- Imperial maintains an adequate network of primary and specialty care providers and routinely monitors how effectively the network meets the needs and preferences of its membership.
- Access and timeliness standards:
 - Regular or routine care appointment: within 15 days;
 - Urgent care appointment: within 48 hours; and
 - After-hours call by the practitioner or covering provider to the member: within 30 minutes.
 - 90% of members report that they 'always' or 'usually' get an appointment for health care at a doctor's office or clinic as soon as they need it.
 - 90% of members report that they 'always' or 'usually' get a follow-up of routine appointment as soon as they need it;
- Coordination of care and transitions of care;
- Preventative health;
- Member experience with healthcare services provided;
- Provider experience with Utilization Management; and
- Medical record audit results.

Goals and Objectives

Continually improve member experiences by measuring outcomes, and continuously improve all aspects of the healthcare continuum. This shall be accomplished through the following objectives:

- Develop and maintain an ongoing monitoring system to detect problems of quality of care or service with individuals or systems encountered by members;
- Develop, implement, and evaluate corrective action plans when deficiencies have been identified;
- Identify, implement, and assess quality improvement initiatives in the areas of quality of care, service and member safety;
- Incorporate internal and external regulatory standards related to quality improvement activities;
- Utilize results from practitioner performance issues which are obtained from a variety of sources:
 - Quality of care and service issues reported during the appeal and grievance process investigation;
 - Quality indicators, and audit/survey studies conducted throughout the year for credentialing, recredentialing, and contracting of health care providers and facilities;
- Design and maintain a QM process that supports continuous quality improvement using the cyclical methodology of planning, doing, studying, and acting;
- Preventive Health: implementing USPSTF and other evidence-based guidelines to reduce morbidity and mortality for members;
- Collaborates with health plans in the completion of health appraisals for Imperial members. This gives members the opportunity to engage actively in managing their own health care by encouraging them to complete a health risk assessment and obtain information about their health status;
- Pursue opportunities for improvement in the health status of the membership by referring them to programs that include preventative care services, health promotion, and health education;
- Pursue collaborative agreements with community-based organizations to meet the socioeconomic needs of Imperial members and improve health equity in the communities it serves;

- Use health plan data to analyze the effectiveness of the DM and other chronic disease management programs to Imperial members and implement actions if an opportunity for improvement is identified;
- Plan on re-measuring the actions taken;
- Pursue opportunities for improvement by analyzing the results of measuring member experience surveys;
- Establish clinical and service indicators that reflect the demographic characteristics of the membership population;
- Conduct Inter Rater Reviewer Reliability (IRR) on physicians and registered nurses (RNs) and licensed vocational nurses (LVNs) that make UM decisions, at least annually;
- Ensure QM activities are linked and coordinated with other services, UM, claims, credentialing, and recredentialing;
- Evaluate annually the effectiveness of the previous year's QM program, activities, and interventions; and
- Train staff with required QI activities, as needed.

Strategy

The planning and implementation of annual QM Program activities follows an established process and includes the following components.

Work Plan

Annually, the Quality Management Committee (QMC) approves a QM work plan, which details the current year program initiatives to achieve established goals and objectives, including the specific activities, methods, projected time frames for completion, and project leader for each initiative.

The scope of the work plan incorporates the needs, input, and priorities of Imperial. Work Plan initiatives are either clinical or non-clinical and address the quality and safety of clinical care and quality of service.

Initiatives include, but are not limited to, planned monitoring activities for previous initiatives, disease-specific interventions, special projects, quality improvement studies, and the annual evaluation of the QM program. The QMC oversees the prioritization and implementation of clinical and non-clinical work plan initiatives. STOP)

Quality Improvement Initiatives

Imperial's current quality improvement activities that measure and monitor access to care are as follows:

- Appointment availability studies; and
- Initial health assessment monitoring.

Imperial's current quality studies that measure and monitor provider and member experience are as follows:

- Consumer Assessment of Health Care Providers and Systems (CAHPS);
- Provider experience survey;
- Member grievance review; and
- Member experience surveys.

Imperial's current quality studies that evaluate preventive and chronic care, as well as coordination, collaboration, and patient safety, are as follows:

- Healthcare Effectiveness Data and Information Set (HEDIS);
- Coordination of care studies; and
- Patient safety studies.

Imperial's current quality studies that evaluate appropriate care for Members with complex medical needs are as follows:

- Complex case management annual evaluation; and
- Disease specific quality studies.

Imperial’s current quality studies that evaluate our ability to serve a culturally and linguistically diverse membership are as follows:

- Annual provider language competency study;
- Annual cultural and linguistic study;
- Ongoing monitoring of interpreter service use; and
- Ongoing monitoring of grievances.

Measurement Process

Imperial uses quality measures to regularly monitor and evaluate the effectiveness of quality improvement initiatives and compliance with internal and external requirements. Imperial reviews and evaluates, no less than on a quarterly basis, the reports available from the health plan. IMPERIAL measures performance against community, national, or internal baselines and benchmarks when available and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews. The findings are reported to the QMC.

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, and announcements. Imperial implements the following:

- Providers are educated regarding quality improvement initiatives through on-site quality visits, provider newsletters, specific mailings, and Imperial’s website ;
- Specific performance feedback regarding actions or data is communicated to providers;
- General and measure-specific performance feedbacks are shared via special mailings, provider newsletter, and Imperial’s website;
- - Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements;
 - Performance indicators are also used to identify quality issues. When identified, Imperial’s QM staff investigates cases and determines the appropriate corrective action plans (CAP). IMPERIAL subcommittees review cases involving patient safety and quality of care issues and recommend actions to the QMC;
 - Providers or practitioners that are significantly out of compliance with QM requirements must submit a CAP. Persistent non-compliance, or failure to adequately address or explain discrepancies identified through oversight activities, may result in freezing of new Member enrollment; a requirement to subcontract out the deficient activities within the MSO or Independent Physician Association (IPA); de-delegation of specified functions; or termination of participation or non-renewal of the agreement with IIC.

Annual Evaluation and Update of the QM Program

Imperial’s QM Staff, including the Chief Medical Officer, evaluates and reviews the effectiveness and progress of the QM Program and Work Plan on an annual basis and provides updates as needed. A yearly summary of all completed and ongoing QM program activities addresses quality and safety of clinical care and quality of service. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, and methodologies used.

- The report includes pertinent results from QM Program studies, patient access to care, Imperial’s standards,

physician credentialing and facility review compliance, member experience, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to members. Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues, with analysis of results, including barrier analysis, to verify improvements. The CMO presents the results to the QMC for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary. Also included is a work plan for the coming year. The work plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

Monitoring Activities

Imperial performs a series of activities to monitor the IPA and other delegated entities.

For Imperial's management, and **when there is delegation**, the following activities take place:

Annual Delegation Oversight Audit using a designated audit tool:

- Joint operations meetings;
- Review of grievances and other quality information;
- Specified audits;
- Focused approved and denied referral audits;
- Focused case management audits;
- Focused practitioner audits for clinical care;
- Facility and medical record reviews;
- Utilization data review; and
- Provider satisfaction surveys.

Enforcement and Compliance

The QMC is responsible for monitoring and oversight of the QM Program, including enforcement of compliance with Imperial standards and required activities.

In general, to obtain compliance when deficiencies are noted, CAPs are requested and followed up on.

Authority and Responsibilities

Board of Directors

Through the QMC, the Board of Directors (Board) has the ultimate responsibility and authority for the quality of care and

service delivered by member providers. The Board reviews and approves the QM program and the QM work plan on an annual basis.

Chief Executive Officer

Imperial's Chief Executive Officer (CEO) has organizational responsibility for the QM program and ensures adequate resources and qualified staffing in order to execute the QM functions. The CEO reports to the Board.

Senior Medical Director

The Senior Medical Director (SMD) for Imperial is responsible for the daily oversight of QM activities. The SMD reports to Imperial's CEO.

QMC Structure

The QMC reports directly to the Board. The QMC has primary responsibility for overseeing implementation of the QM program and the QM annual work plan. The QMC recommends policy decisions, reviews and evaluates the results of QM activities, recommends corrective action plans, and ensures implemented plans are effective.

The QMC is interdisciplinary, with membership appointed by the Board in accordance with the bylaws. Operation of the QMC is by simple majority. No committee member shall vote on any case in which he/she is personally involved. An Imperial physician appointed by the Board chairs the QMC. There are three voting members in the QMC, which include network physicians from Primary Care, as well as specialty physicians. A quorum is achieved with two member Physicians present.

Active participation on the QMC includes consistent meeting attendance, involvement in discussions of agenda items, analyzing results, and assisting in follow-up and problem resolution.

QMC members are appointed annually to assure broad representation and may be reappointed at the discretion of the Board.

Imperial's non-physician employees are non-voting participants.

Imperial's Medical Director or their designees may attend meetings with prior notification and sign a confidentiality statement. The QMC is scheduled to meet quarterly.

Issues that arise prior to a scheduled meeting which require immediate action will be taken directly to Imperial's CMO for review, who may refer the issue to the Medical Director or call an ad hoc QMC quorum.

QMC Subcommittees

The following Subcommittees, chaired by Imperial's Senior Medical Director or designee, report findings and recommendations to the QMC. The subcommittees meet at least quarterly, and more frequently if necessary.

Peer Review

The Peer Review (PR) subcommittee is responsible for PR activities for Imperial.

Structure

The PR subcommittee is composed of Imperial's medical directors or designated physicians' representative of network practitioners. A behavioral health practitioner and any other specialist, not represented by committee members, serve on an ad hoc basis for related issues.

Function

The PR subcommittee serves as the committee for clinical quality review of practitioners, evaluates and makes decisions

regarding member or provider grievances as well as clinical quality of care cases referred by the health plans.

Credentialing

The credentialing subcommittee performs credentialing functions for providers who either directly contract with Imperial or for those submitted for approval of participation in Imperial's network by IPAs that have not been delegated credentialing responsibilities.

Role

The credentialing subcommittee is responsible for reviewing individual providers who contract directly with Imperial. This subcommittee denies or approves their participation in Imperial's network.

Structure

The credentialing subcommittee is composed of multidisciplinary participating PCPs or specialist's representative of network practitioners. A behavioral health practitioner and any other specialist not represented by committee members may serve on an ad hoc basis for related issues.

Function

The credentialing subcommittee provides thoughtful discussion and consideration of all network practitioners being credentialed or re-credentialed. The subcommittee also reviews practitioner qualifications, including adverse findings, and approves or denies continued participation in the network.

If delegated for facility site review, Imperial completes a site review as part of its initial credentialing process when adding a new provider to its provider network who works at a site the organization has not previously reviewed.

The recredentialing review takes place every three (3) years. IMPERIAL ensures that decisions are non-discriminatory.

Pharmacy and Therapeutics (P&T)

The P&T subcommittee performs ongoing review and modification of Imperial's formulary and related processes as well as oversight of the pharmacy network, including medication prescribing practices by Imperial's providers.

The P&T subcommittee assesses usage patterns by members and assists with study design, clinical guidelines, and other related functions. The subcommittee is responsible for reviewing and updating clinical practice guidelines that are primarily medication related.

Role

The P&T subcommittee is responsible for maintaining a current and effective formulary, monitoring medication prescribing practices by Imperial practitioners, and under and over-utilization of medications.

Structure

The P&T subcommittee is composed of clinical pharmacists and designated physician's representative of the network providers. A behavioral health practitioner and any other specialist not represented by committee members may serve on an ad hoc basis for related issues.

Function

The P&T subcommittee serves to objectively appraise, evaluate, and select pharmaceutical products for formulary inclusion and exclusion. The subcommittee provides recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary medications on an ongoing basis. The subcommittee also ensures that decisions

are based only on appropriateness of care and services. The P&T subcommittee is responsible for developing, reviewing, recommending, and directing the distribution of disease state management or treatment guidelines for specific diseases or conditions that are primarily medication related.

Utilization Management (UM)

The medical services committee (MSC) performs oversight of UM activities conducted by to maintain high quality health care as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.

Role

The MSC directs the continuous monitoring of all aspects of UM and CM administered to members.

Structure

The MSC is composed of Imperial medical directors, or designated physicians representative of network practitioners. A behavioral health physician and any other specialist not represented by committee members may serve on an ad hoc basis for related issues.

Function

The MSC reviews and approves UM and CM policies and procedures annually. The committee monitors for over and under-utilization and ensures that UM decisions are based only on appropriateness of care and service. Additionally, the MSC annually reviews the UM program, policies and procedures, work plan, and evaluation.

The QMC reviews and updates preventive care and clinical practice guidelines that are not primarily medication related.

QMC Responsibilities

- Annually review, modify, and approve:
 - o Evaluation of Previous Year QM Program;
 - o QM Program;
 - o QM Workplan; and
 - o QM Policies& Procedures;
- Review and acceptance of:
 - o Preventive health guidelines received from Health Plans;
- Ongoing review of:
 - o Health Plan reports;
 - o Standards for over and under utilization;
- Identify opportunities to improve care; Ensure integration of QM and UM activities;
- Analyze the results of QM activities to determine if there are opportunities for improvement;
- Ensure overall program effectiveness by evaluating the administration of the program throughout all service areas;
- Review potential quality of care and quality of service issues referred from the UM committee and credentialing committee;
 - o Forwards identified issues to the specific health plan;
 - Evaluates and approves reports sent to the Board;
- Review the results of annual health plan audits and evaluates any need for actions that arise from the results;

- Ensures that the information and findings of studies, surveys, and audits are used to detect trends, patterns of performance, or potential problems, and that CAPs are implemented. It also ensures that necessary information is communicated to the relevant providers, departments, or institutions when problems or opportunities to improve care and/or service are identified;
- Identifies findings appropriate for inclusion in provider quality files that are reviewed at the time of recredentialing. The committee may choose to send information to the credentialing committee prior to reappointment, according to its discretion.

QMC Confidentiality Statement

All members of the QMC shall be required to sign a confidentiality statement at least annually. The confidentiality agreement will be kept on file at Imperial's offices. All QMC records and proceedings are confidential and protected as provided by the state's Evidence Code, whether marked: "Confidential and protected as defined by state Evidence Code." Signed minutes are maintained in a locked file at IMPERIAL offices, available only to authorized persons.

Committee Minutes

QMC minutes and documents may be reviewed by authorized Imperial representatives.

However, no copies will be provided, and confidentiality of the information will be preserved.

The QMC implements the following practices:

- A standardized agenda and minutes format is used for all meetings. Minutes are taken during the meeting to reflect all committee activities, decisions, and actions. Approved agendas and minutes are kept in a confidential manner at Imperial offices;
- A copy of the approved minutes is forwarded to the following Board meeting;
- Minutes shall include—but are not limited to—the following subjects;
- Discussion of QM program issues;
- Practitioner behavior;
- Selection of important aspects of care and performance measures to monitor and evaluate;
- Analyses of results of member and provider experience surveys; and
- Analyses of health plan reports addressing accessibility, availability, and medical record audits.

To ensure follow-up on all agenda items, issues are carried on the agenda until resolved. The finalized minutes are reviewed by the committee chairperson and are submitted to the QMC for approval at the next scheduled meeting. Minutes will reflect review, changes if necessary, and approval by the committee.

Clinical Practice Guidelines

Imperial is committed to improving health with optimal outcomes. Clinical practice and preventive health guidelines assist physicians by providing a summary of evidence-based recommendations for the evaluation and treatment of preventive aspects and select common acute and chronic conditions.

Imperial's clinical practice guidelines focus on important aspects of care with recognized, evidence-based, and measurable best practices for high-volume diagnoses. The basis of the guidelines includes a variety of sources that are nationally recognized, evidence-based, or are expert consensus documents. Additional points have been included where medical literature and expert opinion are noted. Network physician involvement is a crucial part of the guideline development as well as adoption for the organization after approval by Imperial's QMC and MSC.

If you have any questions regarding the clinical practice guidelines, contact the Quality Department.

Quality Management (QM) and Improvement (QI) Delegation Oversight:

Imperial provides oversight, consultative, and educational services for all delegated entities.

Pre-Delegation Assessment / Evaluation

Imperial conducts pre-delegation evaluation prior to implementing delegation.

Delegation Agreement

When there is QI sub-delegation, a delegation agreement (Agreement) is executed outlining the responsibilities and activities of the delegated entity that is delegated to provide QM services. The Agreement includes the following:

- Specific QI activities performed by the delegate, in detailed language;
- Specific QI functions that are not delegated and will be retained internally;
- The use of protected health information (PHI) by the delegated entity, with the following provisions:
 - A list of the allowed use of PHI;
 - Specifics regarding the use and disclosure of PHI;
 - A description of safeguards to protect the information from inappropriate use or further disclosure;
 - A stipulation that the delegate ensure that sub-delegates have similar safeguards to provide reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI;
 - A stipulation that the delegate provides individuals with access of their PHI;
 - That the delegate ensures that PHI will be secured through basic protections or physical facilities that store PHI in any form. It will also ensure that electronic systems are protected from unauthorized access and internal and external data tampering.

Communication to Imperial's Providers & Delegates

Imperial provides the following information to the network provider and its delegated entities:

- Member experience data, if delegated by Imperial or contracted health plan;
- Data from:
 - o Complaints;
 - o CAHPS 5.0 H Survey results;
 - o Other data collected on members' experience with the delegate's services; and
 - o Clinical performance data.
- HEDIS measures, claims, and other clinical data collected by the organization or its contracted health plan, if applicable.

Provider Contracting

Imperial's contracts with providers specifically require and/or include the following:

- Providers cooperate with QI activities;
- Providers maintain the confidentiality of member information and records;
- Providers allow the organization to use their performance data for quality improvement activities;
- An affirmative statement indicating providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations;
- Provider manual or policies are considered extensions of the contract.

Imperial's contracting staff conducts periodic medical record audits, and at least an evaluation every two (2) years for contracted providers with more than fifty (50) members, to determine compliance with medical record standards and achievement of performance goals.

Audit results with deficiencies found will be reported to the QMC, credentialing committee, and the practitioner. The following are the recommended thresholds and actions required:

Continuity and Coordination of Care & Transitions of Care

Imperial takes an active role in facilitating patient care across transitions and settings. Imperial's policies and procedures support providers in continuity and coordination of care across settings or transitions between medical and behavioral health services and between practitioners and providers.

The policies and procedures include medical and behavioral health care with the focus on:

- Members getting the care they need; and
- Providers getting the information they need to provide the care members need.
- Member Safety

Imperial continuously monitors patient safety to support providers in improving the safety of their practices.

- PCP Offices
This study assesses PCP compliance with Imperial and state HHS standards for patient safety and identifies common areas of deficiency in physical facility accommodations and infection control practices throughout Imperial's network.
- Inpatient Facilities
Imperial considers the quality of care in acute, rehabilitation, and skilled nursing facilities to be a top priority. To ensure member safety, Imperial assesses, tracks, and reviews the following measures:
 - o Readmission reports;
 - o One day length of stay reports;
 - o Post-op wound infection referrals;

- o Quality of Care referrals for any adverse outcome related to an inpatient stay.

QM Activities

- Standing annual activities included in the QM program are as follows:
 - o Review of health plan audits related to:
 - o Access audits (e.g., a member's ability to receive an appointment with a provider within a specified time frame, depending on the type of appointment);
 - o Availability audits (e.g., a member's ability to contact a provider according to protocols); and
 - o Office waiting time audits (e.g., members not waiting more than 30 minutes on average, per provider, for their scheduled appointments);
- Review of member experience survey results and development of CAPS if indicated;
- Review of provider experience surveys and development of CAPS if indicated;
- Clinical practice guidelines development and adoption; and Ongoing quality of care and case reviews per policy and procedure.

QM Annual Work Plan

- The QM annual work plan is developed and implemented to assist in achieving the above goals in a manner that is organized, systematic, and ongoing. The basic method of planning, doing, studying the results, and implementing needed improvements is the approach that best supports QM and quality improvement activities.
- The QM annual work plan will include the following elements in its structure:
 - o Measurable objectives for all projects and activities;
 - o Name of person accountable for each activity;
 - o Time frame for completion for each activity;
 - o Monitoring of previously identified changes, issues, and corrective actions;
 - o Scheduled date for program project and activity re-evaluation.

Coordination of UM and QM Functions

- The UM program, the MSC, with its emphasis on medical service utilization management, and the QM program, which focuses on the concepts of QM and continuous quality improvement, work in conjunction with one another. Imperial has created linkages between the two programs through committee structures and processes.
- Potential quality issues are identified by all departments and committees. The UM department and the QMC use the established referral process of case management and concurrent review to refer any sentinel events and potential quality issues for review by the QMC. Similarly, any potential UM issues identified by the QMC are referred to the UM Department and MSC for review. The issues are investigated and reviewed by the respective departments and committees when corrective actions may be recommended. The UM and QMC provide an environment to ensure that each program is functioning in concert with the other.

QM Process

The QM process includes ongoing evaluation of the overall effectiveness of the QM Program. Actions are taken to implement the appropriate changes that demonstrate improvement in the quality of clinical care or service to members and providers. The process is implemented on a continuous basis with re-evaluation and subsequent corrective actions addressed. Elements of this process include the following:

Identification:	Select an area for potential improvement.
Measure:	Audit findings, internal and external experience reports, other survey findings, etc.
Act:	Implement corrective actions or improvement activities.
Reassess:	Re-measure to identify the effectiveness of the improvement activities.

The **QM process** is integrated across all departments. Key indicators of clinical and service quality that reflect the needs of members, providers, and health plans have been developed. Standards, goals, guidelines, or benchmarks will be defined for each indicator. Action plans are implemented and monitored to address those areas that fall below the indicated standards.

Annual QM Program Evaluation

The QMC provides an annual evaluation of the effectiveness of the QM program and work plan activities to the Board. The report includes:

- Progress made on achieving goals of the program;
- Summary and trending of monitoring and evaluation activities;
- Special studies and reports;
- Follow-up actions taken on previous studies and reports;
- Effectiveness of those actions and demonstrated improvement in the quality of care and service provided;
- Descriptions of how the network has changed as a result of QM activities;
- Suggestions for activities to be included in the program; and
- Recommendations on future QM activities, work plan revisions, and changes to the overall Program. The Board may approve the recommendations and report or may make independent recommendations.

SECTION 13. PROVIDER AND HOSPITAL ROSTER

13.1 Laboratory

Quest Diagnostics (Please see Patient Service Centers Roster)
8401 Fallbrook Ave.
West Hills, CA 91304
866-MYQUEST (1-866-697-8378)
www.QuestDiagnostics.com

13.2 Radiology/Diagnostic Centers

Refer to the list of contracted providers sent to you by Imperial.

13.3 Contracted Hospital Facilities

Imperial uses contracted hospital and inpatient facilities (skilled nursing, rehab, etc.). Imperial will periodically send the list of contracted hospitals and facilities for the health plan to PCPs. If the PCP has an immediate need to know the contracted hospitals and facilities, please contact the UM department, look on Imperial's website, or contact an Imperial provider services representative.

13.4 PCP and SPECIALIST ROSTER

Refer to the list of contracted providers sent to you by Imperial.

SECTION 14. CLAIMS

Overview:

The focus of Imperial's claims department is to ensure claims are processed timely and accurately and in accordance with state and federal regulations. Imperial has established a toll-free telephone number for providers to access a representative in the customer service department. Providers may call (800) 595-0619.

Timely Claims Submission:

Clean claims for Marketplace members are completed within 30-calendar days and 60-calendar days for contracted providers unless otherwise noted in the provider agreement. For non-clean claims, the provider will receive a written request identifying Imperial's claim number, the date the claim was received, the patient's first and last name, the patient ID, the date of service, and an explanation as to the information required to adjudicate the claim. If the requested information is not received, the claim will be closed, and the provider will receive an Explanation of Payment (EOP) with a detailed explanation as to the reason why the claim was denied.

A "clean claim" is defined as a claim for a covered service that has no defect or impropriety and otherwise conforms to the clean claim requirements for equivalent claims under original Marketplace. A defect or impropriety includes, without limitation, lack of data fields required by Imperial or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Imperial, the claim is not considered clean.

Submission of Claims:

As an Imperial participating provider, you have agreed to submit all claims within the timeframes outlined in your agreement.

While Imperial prefers claims to be submitted electronically, both electronic and paper claims are accepted. Claims must be sent to the following:

Imperial Insurance Companies, Inc.:

- **Arizona Exchange Claims Department**
P.O. Box 60567
Pasadena, CA 91116
• Electronic Office Ally Payor ID# IEXAZ
- **Texas Exchange Claims Department**
P.O. Box 61300
Pasadena, CA 91116
• Electronic Office Ally Payor ID# IEXTX
- **Nevada Exchange Claims Department**
P.O. Box 60590
Pasadena, CA 91116
• Electronic Office Ally Payor ID# IEXNV

Imperial Health Plan of the Southwest, Inc.:

- **Utah Exchange Claims Department**
P.O. Box 60190
Pasadena, CA 91116
• Electronic Office Ally Payor ID# IEXUT

For all claim inquiries, please email: claimsinquiryex@imperialhealthholdings.com

Tax ID and National Provider Identifier Requirements

Imperial requires the payer-issued Tax Identification Number (TIN) and National Provider Identifier (NPI) on all claim's submissions.

Claim Format:

Appropriate forms and data elements must be present for a claim to be considered a clean claim.

Documentation

Imperial reserves the right to request documentation of utilization for any claim, even when that claim has a corresponding valid authorization. In these cases, Imperial requests medical records for utilizations with a valid authorization in order to ensure medical necessity and the accuracy of billing. The utilization is authorized, but we need to validate the individual diagnoses and services.

Billing and balance billing members

You may bill or charge Imperial members for applicable copayments, coinsurance and/or deductibles. Your provider agreement addresses the circumstances under which you can bill Imperial members. However, Imperial wants to protect our members from unnecessary or inappropriate billing.

Therefore, you may not balance bill members when claims are denied for administrative reasons, such as lack of referral or authorization when one is required.

Other billing situations:

Billing an Imperial member who has exhausted their benefits: When a member has exhausted their benefits, you cannot charge them more than the contracted rate if you continue to see them. For example, if a plan covers 10 visits but you provide 12, you cannot bill the member more than the contracted rate for the two additional visits. As noted above, you are also required to notify the member that their insurance does not cover the two additional visits and obtain the member's prior written consent to pay for the two additional visits.

Billing members for services denied by Imperial: Imperial may adjust or deny payment of covered services upon UM review. You cannot bill a member for a service that we denied because of our UM review. If your bill for a covered service is adjusted because of a UM or bill review, you cannot balance bill the member for the amount that Imperial does not pay. An example of this would be if a member is approved to stay in a hospital for eight days but the hospital does not release them for ten days. In this situation, Imperial will not cover the two additional days, but the hospital cannot bill the member for the two additional days.

Claims Overpayments:

If determines that it has overpaid a claim, Imperial will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date(s) of service, and a clear explanation of the basis upon which Imperial believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

If the provider contests Imperial's notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to Imperial stating the basis upon which the provider believes the claim was not overpaid.

If the provider does not contest Imperial's notice of overpayment of a claim, the provider must reimburse Imperial within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

Imperial may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when: (1) the provider fails to reimburse Imperial within the timeframe set forth in Section 16.2.B. above; and/or (2) Imperial's contract with the provider specifically authorizes Imperial to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, Imperial will provide a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim(s).

Coordination of Benefits

Imperial shall coordinate payment for covered services in accordance with the terms of a member's benefit plan, applicable state and federal laws, and applicable CMS guidance. If Imperial is the secondary insurer, providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to. Any balance due after receipt of payment from the primary payer should be submitted to Imperial for consideration, and the claim must include information verifying the payment amount received from the primary payer. Provider will need to send a copy of the primary insurer's explanation of benefits.

Imperial may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

Members under the Commercial Marketplace line of business may be covered under more than one insurance policy at a

time. In the event that Imperial has information on file to suggest the member has other insurance primary to Imperial, Imperial may deny the claim. If the primary insurance has terminated, the provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the provider is responsible for submitting the initial claim with proof that payment has been returned to the primary insurance carrier.

When benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds Imperial's liability, no additional payment will be made.

Claims Payment Disputes:

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Imperial in writing within 60 calendar days of the date of denial set forth in the EOP.

- When submitting a dispute, the provider must provide the following information: ·
- Date(s) of service;
- Member name;
- Member ID number and/or date of birth;
- Provider name;
- Provider TIN;
- Total billed charges;
- Provider's statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g., proof of timely filing, medical records).

Contracted providers must use the provider dispute resolution form and mail it to the address on the form. Requests and form should not be sent to the appeals department.

SECTION 15. OFFICE ALLY & ONLINE SERVICES

Web Portal, Imperial Health Plan Website: www.imperialhealthplan.com

Please visit our website to verify eligibility, submit claims, authorization submission, and inquiry status information. Providers can also take advantage of our online service to download a copy of the PCP and specialist provider rosters. You can also search individually for a PCP, specialist, and ancillary provider.

Our on-line features include:

- Authorization status inquiry;
- Authorization submission;
- Claims status;
- Provider rosters;
- Provider search inquiries; and
- Member eligibility verification.

To set up an account with Imperial's web portal, contact us by phone at (800) 595-0619 (portal assistance).

Office Ally providers are encouraged to set up an account to start submitting all claims through Office Ally. Imperial has opted to partner with Office Ally for all claims submissions.

Please note our payer ID's:

AZ: IEXAZ, TX: IEXTX, NV: IEXNV, UT: IEXUT

To set up an account with Office Ally, please contact them directly at (866) 575-4120 or email them at OfficeAlly.com.

SECTION 16. PATIENT'S RIGHTS AND RESPONSIBILITIES

It is the Patient's Rights to:

1. A reasonable response to the patient's requests and needs for treatment or service, within the hospital's capacity, its stated mission, and applicable law and regulation;
2. Considerate and respectful care, as follows:
 - a. the care of the patient includes consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness;
 - b. the care of the dying patient optimizes the comfort and dignity of the patient through:
 - (i) treating primary and secondary symptoms that respond to treatment as desired by the patient or surrogate decision maker;
 - (ii) effectively managing pain; and
 - (iii) acknowledging the psychosocial and spiritual concerns of the patient and the family regarding dying and the expression of grief by the patient and family;
3. Make decisions involving his or her health care, in collaboration with his or her physician, to include the following:
 - a. the right of the patient to accept medical care or to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of such refusal; and
 - b. the right of the patient to formulate advance directives and to appoint a surrogate to make health care decisions on his or her behalf to the extent permitted by law. Advance directives are written instructions recognized under state law relating to the provision of health care when individuals are unable to communicate their wishes regarding medical treatment. The advance directive may be a written document authorizing an agent or surrogate to make decisions on an individual's behalf (a medical power of attorney for health care), a written or verbal statement (a living will), or some other form of instruction recognized under state law specifically addressing the provisions of health care;
 - (i) a hospital shall have in place a mechanism to ascertain the existence of, and, as appropriate, assist in the development of advance directives at the time of the patient's admission;
 - (ii) the provision of care shall not be conditioned on the existence of an advance directive; and
 - (iii) an advance directive(s) shall be in the patient's medical record and shall be reviewed periodically with the patient or surrogate decision maker if the patient has executed an advance directive;
4. Access information necessary to enable him or her to make treatment decisions that reflect his or her wishes; a policy on informed decision making shall be adopted, implemented, and enforced by the medical staff and governing body and shall be consistent with any legal requirements;
5. Receipt, at the time of admission, of information about the hospital's patient rights policy(ies) and the mechanism for the initiation, review, and when possible, resolution of patient complaints concerning the quality of care;
6. Participation in the consideration of ethical issues that arise in the care of the patient. The hospital shall have a mechanism for the consideration of ethical issues arising in the care of patients and to provide education to care givers and patients on ethical issues in health care;
7. Be informed of any human experimentation or other research or educational projects affecting his or her care or treatment;

8. To personal privacy and confidentiality of information;
9. Access information contained in the patient's medical record, within the limits of the law; and
10. the right of the patient's guardian, next of kin, or legally authorized responsible person to exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient:
 - a. has been adjudicated incompetent in accordance with the law;
 - b. is found by his or her physician to be medically incapable of understanding the proposed treatment or procedure;
 - c. is unable to communicate his or her wishes regarding treatment; or
 - d. is a minor;
11. Follow the plans and instruction for care agreed upon with his/her practitioners;
12. Provide, to the extent possible, information that the medical group and its practitioners and providers need in order to care for the patient;
13. Contact his/her physician or health plan with any questions or concerns about health benefits or health care services;
14. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.

SECTION 17. NCQA REQUIREMENTS

Member Experience:

Our member experience program includes proactive monitoring of member satisfaction through bi-annual surveys and a dedicated complaint resolution process that ensures all grievances are addressed within five business days. Results from these surveys and the resolution process will be reviewed quarterly by our Quality Improvement team to implement actionable changes that enhance member satisfaction.

1. Network Management:

Overview: Our network management strategy includes rigorous provider screening, ongoing performance assessments, and regular updates to our provider directory.

- Providers are required to meet strict quality and accessibility standards, including minimum visitation times, geographic distribution, and cultural competence training. Our network adequacy is assessed annually through member feedback and geographic analysis to ensure all members have access to the required range of services within reasonable travel distances.
- Our network management strategy ensures access to a comprehensive range of providers that meet our criteria for quality and performance. The network is reviewed annually to ensure adequate access for all members to primary care, specialty care, and emergency services. This includes ongoing monitoring of provider availability and service utilization to adjust the network as needed to meet member needs.

2. Population Health Management

Overview: Our Population Health Management initiatives are structured around proactive health risk assessments and targeted intervention programs that address both chronic conditions and preventive care.

- Each member is assessed annually to identify risk factors, and based on these assessments, personalized health plans are developed and implemented. These plans include regular health screenings, disease management programs, and wellness initiatives, all tracked through our integrated data management system to measure effectiveness and outcomes.

3. Utilization Management

Utilization Management is governed by evidence-based criteria and protocols to ensure appropriate use of resources while maintaining the highest standards of care. All utilization decisions are made by qualified health professionals, and denials of coverage include a clear rationale and instructions for appeal. Appeals are processed within the regulatory timelines, with all decisions subject to a fair and impartial review process that includes opportunities for provider and patient input.

- Utilization management decisions are made following evidence-based guidelines and standards.
- Each decision is documented and includes the criteria used for the decision.
- All denials of coverage or service are communicated to the provider and member in writing, explaining the reasons for the decision and the process for appeal.

4. Quality Improvement

Overview: Our Quality Improvement program is centered on continuous performance evaluation and member health outcomes.

- This includes the use of advanced analytics to track and report on care quality, patient safety, and service utilization. Improvement initiatives are prioritized based on areas where performance metrics indicate potential for significant impact on health outcomes, and these initiatives are reviewed bi- annually by the Quality Improvement Committee to ensure alignment with best practices and regulatory standards.

5. Quality Improvement Program

The Quality Improvement Program is structured to include the following functional areas and their responsibilities:

The QI program has dedicated resources and analytical support to carry out its activities.

- QI Committee: Oversees the QI program, analyzes data, and recommends improvements.
- QI Staff: Collects and analyzes data, develops and implements QI initiatives.
- Physician Advisor: Provides clinical expertise and guidance to the QI Committee.

QI 6.1 Annual Work Plan

Overview: The QI program develops an annual work plan that outlines the QI activities and objectives for the year.

- The work plan includes a time frame for completion of each activity, the staff members responsible, and a process for monitoring previously identified issues.
- The work plan is developed with input from stakeholders and is reviewed and approved by the QI Committee.

QI 6.2 Annual Evaluation

Overview: The QI program conducts an annual written evaluation of its effectiveness.

- The evaluation includes a description of completed and ongoing QI activities, trending performance measures, and an assessment of the program's overall effectiveness in improving

the quality and safety of clinical care.

The evaluation is used to identify areas for improvement and to make recommendations for changes to the QI program.

QI 6.3 Committee Responsibilities

The QI Committee is responsible for:

- Recommending and revising policies for the effective operation of the QI program.
- Overseeing recommendations and revisions to policies.
- Analyzing and evaluating QI data to identify opportunities for improvement.
- Developing and implementing QI initiatives.
- Ensuring practitioner participation in the QI program.

QI 6.4 Diversity, Equality and Inclusion (DEI)

Overview: The organization is committed to promoting diversity, equity, and inclusion in its QI program.

- The organization has a DEI plan that outlines its goals and strategies for promoting DEI in the workplace.
- The organization believes that a diverse and inclusive workforce leads to better decision-making and improved outcomes for all members.
- The QI program also engages with diverse stakeholders to get their input on quality improvement initiatives.

6. Quality Management Program

The Quality Management program will be evaluated semi-annually, with adjustments made as needed to improve outcomes. Evaluations will include analysis of performance against established goals, member satisfaction surveys, and clinical outcomes. Detailed reports of these evaluations will be submitted to Quality Management Committee and used to drive continuous improvement.

7. Member Rights and Responsibilities

Members will receive a copy of the Member Rights and Responsibilities at the time of enrollment and upon any subsequent updates. This document will also be available on our website and upon request by phone or mail. Providers are required to assist in disseminating this information and ensuring members understand their rights and responsibilities under their health plan.

7.1 Member's Rights and Responsibilities Statement

Members have the right to receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities.

7.2 Distribution of Rights Statement

Overview: The organization distributes its member rights and responsibilities statement to new members upon enrollment.

- The organization also distributes the statement to existing members annually.
- The organization makes the statement available to members in a variety of formats, including print, electronic, and audio.

8. Subscriber Information

Plan will provide subscribers with necessary information regarding coverage, benefits detail, access to care and Plan's ratings. This includes all access to the organization's tools such as online portal, website and membership contact numbers. All tools will follow HIPPA regulations.

8.1 Distribution of Subscriber Information

- The organization distributes subscriber information to new members upon enrollment.
- The organization also distributes the information to existing members annually.
- The organization makes the information available to subscribers in a variety of formats, including print, electronic, and audio.

9. Interpreter Services

- The organization provides interpreter services to members who do not speak English or who have limited English proficiency.
- The organization provides interpreter services in a variety of languages, including Spanish, Chinese, Vietnamese, and Korean.
- The organization provides interpreter services in a variety of formats, including in-person, telephonic, and video.
- Members can access interpreter services by contacting the organization's Member Services department.

10. Accuracy of Marketing Information

Overview: The organization has a process of ensuring that all marketing materials are accurate and comply with NCQA standards.

- The process includes review and approval of all marketing materials by the organization's compliance department.
- The compliance department ensures that marketing materials are consistent with the organization's policies and procedures and that they do not contain any false or misleading information.

11. Assessing Member Understanding of Marketing Materials

- The organization assesses prospective members' understanding of marketing materials through surveys and focus groups.
- The organization uses this feedback to improve the clarity and effectiveness of its marketing materials.

12. Protected Health Information (PHI)

- The organization communicates its policies on the collection, use, and disclosure of PHI to prospective members in a clear and concise manner.
- The organization provides this information in its marketing materials and on its website.
- The organization also provides prospective members with a copy of its Notice of Privacy Practices.

13. Member Claims Access

- Members can track the status of their claims online through the member portal.
- The portal provides information on the stage of the claim in the process, the amount approved, the amount paid, the member's cost, and the date paid.

14. Member Claims Access by Phone

- Members can track the status of their claims by contacting Member Services by phone.
- Member Services representatives can provide information on the stage of the claim in the process, the amount approved, the amount paid, the member's cost, and the date paid.

15. Pharmacy Benefit Information Online

Online availability of pharmacy benefit information, including:

<https://imperialhealthplan.com>

- Covered pharmaceuticals (including tiers, drugs that require a prior authorization, quantity limits, generic substitution, therapeutic interchange or step therapy protocols).
- Determining financial responsibility for a drug.
- Initiating the exceptions process.
- Ordering mail-order prescription refills.
- Finding in-network pharmacy locations.
- Determining the availability of generic substitutes.

Prior authorization is required for all Physician Assisted Drugs (PADs) included on the Prior Authorization List. Detailed instructions for submitting a prior authorization request are available in the Policies and Procedures section of this manual. The Prior Authorization List can be accessed on our website at <https://imperialhealthplan.com>.

This list is regularly reviewed and updated to ensure that any changes in procedures or applicable drug recalls are communicated promptly.

16. Process for Pharmacy Benefit Information Accuracy- Quality Improvement (QI)

- The organization has a QI process for ensuring the accuracy of pharmacy benefit information.
- The process includes regular audits of pharmacy benefit information and a mechanism for members and practitioners to report inaccuracies.
- The organization investigates and corrects any inaccuracies identified.

17. Pharmacy Benefit Updates

- The organization updates pharmacy benefit information on a regular basis or at least monthly to ensure that it is current and accurate.
- The organization notifies members and practitioners of any changes to pharmacy benefit information within 15 days of receiving an update.

18. Personalized Information Online

Access to online availability of personalized information, including:

- Accessing and viewing formularies.
- Checking the status of referrals and authorizations.
- Accessing and viewing their benefits.
- Viewing their Explanation of Benefits (EOB).
- Viewing their claims history.
- Accessing and viewing their allowed services.

Members can access personalized information on health plan services through the member portal, including:

- Accessing and viewing formularies.
- Checking the status of referrals and authorizations.

- Accessing and viewing their benefits.
- Viewing their Explanation of Benefits (EOB).
- Viewing their claims history.
- Accessing and viewing their allowed services.

19. Personalized Information by Phone

Availability of personalized information on health plan services by phone including:

- Accessing and viewing formularies.
- Checking the status of referrals and authorizations.
- Accessing and viewing their benefits.
- Viewing their Explanation of Benefits (EOB).
- Viewing their claims history.
- Accessing and viewing their allowed services.

Members can contact Member Services by phone to access personalized information on health plan services, including:

- Accessing and viewing formularies.
- Checking the status of referrals and authorizations.
- Accessing and viewing their benefits.
- Viewing their Explanation of Benefits (EOB).
- Viewing their claims history.
- Accessing and viewing their allowed services.

20. QI for Personalized Information Accuracy

The organization has a QI process for ensuring the quality and accuracy of personalized information provided to members.

- The process includes regular audits of member-facing systems and materials, and a mechanism for members and practitioners to report inaccuracies.
- The organization investigates and corrects any inaccuracies identified.

21. Email Response Evaluation

The organization regularly evaluates the quality of email responses to member inquiries.

- The evaluation includes an assessment of the timeliness, accuracy, and completeness of email responses.
- The organization uses this feedback to improve the quality of its

22. Complaint Policies and Procedures

22.1 Complaints

- Investigates all practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable.

22.2 Appeal Policies and Procedures

PURPOSE:

To ensure that Imperial Health Plan of the Southwest, Inc./Imperial Insurance Companies, Inc. (Imperial) is complying with all applicable rules and regulations governing the administration of Exchange plans and to define Imperial's processes regarding timely resolution of Member and provider appeals.

POLICY:

Imperial will ensure members have a process for resolving appeals for both coverage and non-coverage decisions made by the plan or its delegated entities in the provision of health care or prescription drug services or benefits. Imperial will fully investigate the content of the appeal and document its findings. Appeal decisions and notifications will be timely. The organization's appeal review does not give deference to the denial decision.

Imperial will maintain a dedicated log or system for processing appeals in a secure centralized location that is readily accessible to appropriate staff.

All information pertaining to appeals is housed in secure on-line folders or within the system.

PROCEDURE:

1. Accepting Appeals:

- Imperial will accept appeals from Members or their representative (with proper authorization) and Providers or Prescribers or Physician office staff.

2. Classification

- Members may contact Imperial to file, make, or request a complaint or grievance, inquiry, coverage request, or appeal.
- Appeal procedures are separate and distinct from initial determination and complaint or grievance procedure. Any communication from a member will be reviewed on a case-by-case basis to determine how it should be categorized.
- The member is not required to use any specific language to indicate what they are requesting.
- Imperial will determine whether the matter or the issue is a complaint or grievance, coverage request, appeal, or combination of more than one category and will inform the member (verbally or in writing) if the issue is a complaint or grievance or an appeal.
- Appeals will be classified as follows:
 - Preservice appeal: An appeal of an adverse decision for coverage of care or services in advance of the member obtaining care or services.
 - Post service appeal: A request to change an adverse determination for care or services that have been received by the member
- If a member raises two or more issues at the same time, each issue will be processed separately and simultaneously (to the extent possible) under the appropriate procedure.
- Imperial has ensured all staff are trained to distinguish between coverage requests, appeals, and complaints or grievances. Staff will thoroughly document the issue and will forward the case to the appropriate processing area immediately upon receipt.
- Any misclassified cases will be sent to the appropriate processing area immediately and the issuing department will be notified of error.

3. Standard vs Expedited/Urgent

- Imperial will expedite all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

Exchange:

- An appeal on an adverse decision for coverage for urgent care.

4. Documentation

- Imperial will accept any information or evidence concerning the appeal from the appellant
- The appeal will be thoroughly documented by A & G. Documentation will include:
 - Date of initial receipt
 - Who made the appeal
 - The appellant's reason for appeal when written or the recipients' transcription when verbal
 - Clinical or other information provided with the appeal request
 - Previous denial and/or appeal history
 - Follow-up activities associated with the denial and conducted before the current appeal
 - Appeal form, if provided
 - Category of the appeal
 - Reason for denial, including medical necessity
 - All actions taken to investigate and resolve the Appeal, including, but not limited to:
 - Denial or Notice of Action letter
 - Original claim
 - EOB
 - EOP
 - EOC
 - Follow-up activities associated with the Appeal.
 - When an appellant fails to submit relevant information by the specified deadline
 - All findings as a result of the investigation
 - Medical Director review and rationale, when appropriate
 - Disposition of the appeal
 - Date of resolution
 - Date of any phone calls & correspondence
 - IRO (Exchange) documentation including:
 - Case files submitted to the IRO
 - Decisions from IRO
 - Appellant notification of IRO decisions
 - Proof of effectuation when necessary
- Any documentation Imperial feels is relevant to the case

Exchange only:

- Members will be given reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.

5. Investigation

- Imperial will conduct a full investigation, which will include, but is not limited to, review of:
 - denial or Notice of Action letter
 - any aspects of clinical care provided
 - UM documentation
 - EOB & EOP
 - claims documentation
 - EOC, if necessary
- Imperial will not defer to the initial denial decision

Exchange only:

- For denials or reductions of coverage, Member will have continued coverage pending the

- outcome of the appeal until the end of the approved treatment period or the determination of the appeal
- Imperial may but is not required to seek reimbursement from the member for payments made.
 - Imperial may, with the Member’s permission, refer the appeal directly to an IRA without conducting an internal review
- Imperial will allow the appellant to submit written comments, documents or other information relating to the appeal
- Imperial will request additional information and response from indicated parties
- Imperial will decide on the information provided
- Imperial will provide language services through bilingual staff or interpreter services to help members through the appeal process
- For appeals that were denial for medical necessity, the appeal will be reviewed by a person who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination and by a practitioner in the same or similar specialty
- The following practitioner types to be appropriate for review of the specified UM denial decisions:
 - Physicians, all types:
 - Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
 - Nurse practitioners:
 - Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
 - In states where Imperial have determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.
 - Doctoral-level clinical psychologists or certified addiction-medicine specialists:
 - Behavioral healthcare denials.
 - Pharmacists:
 - Pharmaceutical denials.
 - Dentists:
 - Dental denials.
 - Chiropractors:
 - Chiropractic denials.
 - Physical therapists:
 - Physical therapy denials.
 - Doctoral-level board-certified behavioral analysts:
 - Applied behavioral analysis denials.
- To be considered a same-or-similar specialist, the reviewing specialist’s training and experience must meet the following criteria:
 - Includes treating the condition.
 - Includes treating complications that may result from the service or procedure.
 - It is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.
- Imperial will authorize or provide the service or benefit as expeditiously as the enrollee’s health condition requires, but no later than the timeframes listed below.
- Upon completion of the investigation a written response will be sent as noted below
- preservice appeal will be responded to within 30 days of receipt of the appeal
- expedited appeals will be responded to within 72 hours
- post service appeals will be responded to within 60 days of receipt of the appeal

6. Notification:

- Imperial will respond to all appeals in writing. Letters will contain,
 - Directly respond to the reason for the appeal
 - Address any new information found during review
 - A response that is understandable to the member
- Does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand
- Explain abbreviations and acronyms in lay person language
 - Disposition of the appeal, including any duration, limitations or coverage rules, as applicable
 - Criterion, or excerpt of criterion, upon which the decision was made
- A copy will be provided upon request
 - A full and complete reason for upholding the denial in terms specific to the member's condition or request
 - Identify all reviewers who participated in making the appeal decision (by title, qualification & specialty only as applicable, not name), including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision
- For each individual, the notice includes:
 - For a benefit appeal:
 - The title (position or role in the organization)
 - For a medical necessity appeal:
 - The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist)
 - Additional appeal rights including description, procedures and time frames, if appropriate
 - Explains Imperial's resolution of the complaint;
 - Reference the benefit provision, guidelines, protocol or similar criteria on which the appeal decision is based
 - Specialization of any physician or other provider consulted
 - Complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal

The appeals process will include the right of the complainant to:

Appear in person before a complaint appeal panel at the site at which the enrollee normally receives healthcare services or at another site agreed to by the complainant; or

- Address a written appeal to the complaint appeal panel

- Resolution letters, and all other documentation, will be sent to the member in the member's preferred language, and based on cultural needs
- Imperial may provide verbal notification of expedited appeals
 - Notification must be communicated to a live person
 - The date and time will be documented
 - Verbal notification will not preclude written notification
- Written notification will be given within 3 days of verbal notification

7. Submission to the IRO

- Imperial will follow CMS and C2C protocol for submission of the case
 - Imperial will notify the Member whenever a case is being forwarded to the IRO
 - Imperial will allow appellants to seek review by an Independent Review Organization (IRO)
 - Imperial timely comply with IRO request for information
 - Imperial will pay for any costs associated with the independent review
- Imperial will comply with the decisions of the IRO
 - Imperial will follow CMS and Maximus, C2 Cor the IRO protocol for effectuation
- Imperial will send written notification to the appellant of a dismissal upon determination but no later than the expiration of the processing timeframe.

REGULATORY REFERENCES:

Texas insurance code title 6. Organization of insurers and related entities subtitle c. Life, health, and Accident insurers and related entities chapter 843 Health maintenance organizations

NCQA HP Accreditation Standards

42 CFR §422.578-590 and 423.580-590

Parts C & D Enrollee Appeals, Organization/Coverage Determinations, and Appeals Guidance Effective August 3, 2022

4.1 Nonbehavioral Complaint Assessment

4.2 Nonbehavioral Improvement Opportunities

The organization has a process for identifying and acting on opportunities to improve its nonbehavioral health care complaint process.

4.2.1 The process includes an annual review of complaint data and feedback from members and practitioners.

4.2.2 The organization takes action to address any identified areas for improvement.

4.3 Behavioral Complaint Assessment

The organization annually assesses member and practitioner experience with behavioral health care complaints.

4.3.1 The assessment includes an analysis of complaint data, including the nature of complaints, the timeliness of resolution, and members and practitioner satisfaction with the complaint resolution process.

4.4 Behavioral Improvement Opportunities

4.4.1 The organization has a process for identifying and acting on opportunities to improve its behavioral health care complaint process.

4.4.2 The process includes an annual review of complaint data and feedback from members and practitioners.

4.4.3 The organization takes action to address any identified areas for improvement.

i. Utilization Management (UM) Program Structure

The UM program is responsible for ensuring that all health care services provided to our members are medically necessary and appropriate. The UM program is staffed by a team of qualified health care professionals, including physicians, nurses, and other allied health professionals.

- The UM staff is responsible for reviewing requests for health care services, applying evidence-based criteria to make UM decisions and communicating with providers and members about UM decisions.
- The UM program also has a process for handling member appeals of adverse UM decisions.

1. Medical Necessity Criteria

- a. The UM program uses objective, evidence-based criteria to make UM decisions.
- b. These criteria are based on the most current medical evidence and are regularly reviewed and updated.
- c. The criteria are used to determine whether a health care service is medically necessary and appropriate for a member's condition.
- d. Providers can obtain a copy of the medical necessity criteria by contacting the UM department.

ii. Role of the Physician in the QI Program

- The QI program is overseen by a designated physician, who is responsible for participating in and advising the QI Committee.
- The physician's responsibilities include reviewing QI data, identifying opportunities for improvement, and developing and implementing QI initiatives.

○

QI Committee's Responsibility for Recommending and Revising Policies

- a. The QI Committee is responsible for recommending and revising policies for the effective operation of the QI program.
- b. The QI Committee also oversees recommendations and revisions to policies.

iii. Patient Safety Strategy

- The organization is committed to providing high-quality, safe health care services to our members.
- The organization has a comprehensive patient safety strategy that includes goals, target populations, and programs
- or services offered to members to promote patient safety.
- The organization's patient safety goals include reducing the incidence of medication errors, falls, and hospital-acquired infections.
- The organization's patient safety programs and services include medication reconciliation, fall prevention, and infection control.

iv. Process for Verifying Provider Credentials

- The organization verifies all provider credentials before contracting with a provider.
- The verification process includes primary source verification of education, training, licensure, and board certification.
- The organization also conducts a background check and reviews the provider's malpractice history.

1. Process for Recredentialing Providers

- a. The organization recredentials all providers every three years.
- b. The recredentialing process includes a review of the provider's performance, including quality of care, member
- c. satisfaction, and compliance with the organization's policies and procedures.

SECTION 18. FORMS & APPENDICES

- 17.1 Direct Referral Form
- 17.2 Direct Referral Form
- 17.3 EZ-Net Portal Application
- 17.4 EZ-Net Portal Guide
- 17.5 Provider Satisfaction Survey Enclosed
- 17.6 Key Contact List



IMPERIAL INSURANCE COMPANIES

Direct Access Referral Form

Complete all sections of the form and give the original to the member. No additional authorization is needed. Retain copy in patient records.

Member Information

Full Name _____ Date of Birth _____ Gender M F

Phone Number _____ Health Plan _____ Member ID# _____

PCP Name _____ PCP Phone # _____ PCP Fax # _____

Diagnosis

ICD code _____ Dx description _____ ICD code _____ Dx description _____

Requested Specialist/Provider

Name _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Phone # _____ Fax # _____

QTY	OUTPATIENT VISITS	
1	99201 - 99204	New Patient Consults
	99211 - 99214	Established Patient Follow-Up (Up to 3 Visits)
QTY	PHYSICAL THERAPY	
	MCR - 9 series MCL - X codes	Physical Therapy Evaluation and 2 treatment visits
QTY	X-RAYS	
	73560 - 73660	Lower Leg, Ankle & Foot
	73090 - 73140	Forearm & Hand
	73030 - 73085	Shoulder & Upper Arm
	73501 - 73552	Pelvic Region & Thigh
	71045 - 71048	Thorax (Chest)
	71100 - 71130	Ribs, Sternum & Sternoclavicular Joint(s)
	72020, 72040, 72070 - 72082	Spine (1-3 views)
QTY	MAMMOGRAPHY	
	77053 - 77054, 77061 - 77067	Breast Screening
QTY	ULTRASOUND	
	76813 - 76817	Other Fetal Evaluations
	76536 - 76800	Neck, Thorax, Abdomen & Spine
	76830 - 76873	Male & Female Genitalia
QTY	DEXA SCAN	
	77080 - 77081	Dual Energy X-ray Absorptiometry

QTY OTOLARYNGOLOGY/ENT		
	69210	Cerumen Removal
	31231	Nasal Endoscopy
	92511	Nasopharyngoscopy
	30901	Cauterization of Epistaxis
	69200	Removal of Foreign Body in Ear
	69420	Myringotomy
	92552	Pure Tone Audiometry
	92557	Comprehensive Audiometry
	92567	Tympanometry
	10021	Fine Needle Aspiration
	95992	Epley Maneuver
QTY LAB		
	81015	UA Microscopic
	81000	UA Dipstick
	81025	Urine Pregnancy Test
QTY OB CARE		
	59400	Total OB Care (w/2 utz)
	76801 - 76817	Other Fetal Evaluations
QTY OPHTHAMOLOGY		
	92002 - 92004	Eye Exam New Patient
	92012 - 92014	Eye Exam & Tx. Established Pt.
	92134	OCT for retina
QTY PODIATRY		
	11720	Debride Nail 1-5
	11055	Trim Skin Lesion
	11721	Debride Nail 6 or more
QTY CARDIOLOGY		
	93306	Transthoracic Echocardiogram (TTE)
	93000	EKG
QTY SCREENING		
	45378 – 45382, 45385	Colonoscopy Screening and Tumor/ Polyp Removal
	G0105 or G0121	Colorectal Screening
	84152, 84153, 84165	Prostate Specific Antigen complexed
	52000	Cystoscopy
QTY HOME HEALTH		
	G0299-G0300	Skilled Nurse Visit (RN or LVN) Evaluation
	52000	Cystoscopy

QTY	MISCELLANEO US	
	11010	Debride skin at fx site
	11011	Debride skin musc at fx site
	11042	Debride skin tissue 20 SQ CM
	11043	Debride musc/fascia 20 sq cm
	11044	Debride Bone 20 sq
	11045	Debride subq tissue add on
	11046	Debride musc/fascia add on
	11047	Debride bone add on
	11055	Trim skin lesion
	11056	Trim skin lesion 2 to 4
	11057	Trim skin lesion over 4
	11102	Tangntl bx skin single lesion
	11103	Tangntl bx skin single eachsep/additional
	11104	Punch bx skin single lesion
	11105	Punch bx skin each sep/additional
	11106	Incal bx skin single lesion
	11107	Incal bx skin each sep/additional

Referring Provider Signature _____ Date _____

Referring Provider _____ Phone # _____ Fax# _____
 Print name



IMPERIAL HEALTH PLAN
OF THE SOUTHWEST

Direct Access Referral Form
EXUT

Complete all sections of the form and give original to the member. No additional authorization is needed. Retain copy in patient records.

Member Information

Full Name _____ Date of Birth _____ Gender M F

Phone Number _____ Health Plan _____ Member ID# _____

PCP Name _____ PCP Phone # _____ PCP Fax # _____

Diagnosis

ICD code _____ Dx description _____ ICD code _____ Dx description _____

Requested Specialist/Provider

Name _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Phone # _____ Fax # _____

QTY	OUTPATIENT VISITS	
1	99201 - 99204	New Patient Consults
	99211 - 99214	Established Patient Follow-Up (Up to 3 Visits)
QTY	PHYSICAL THERAPY	
	MCR - 9 series MCL - X codes	Physical Therapy Evaluation and 2 treatment visits
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	71045 - 71048	Thorax (Chest)
	71100 - 71130	Ribs, Sternum & Sternoclavicular Joint(s)
	72020, 72040, 72070 - 72082	Spine (1-3 views)
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QTY	ULTRASOUND	
	76813 - 76817	Other Fetal Evaluations
	76536 - 76800	Neck, Thorax, Abdomen & Spine

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	77080 - 77081	Dual Energy X-ray Absorptiometry

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	31231	Nasal Endoscopy
	92511	Nasopharyngoscopy
	30901	Cauterization of Epistaxis
	69200	Removal of Foreign Body in Ear
	69420	Myringotomy
	92552	Pure Tone Audiometry
	92557	Comprehensive Audiometry
	92567	Tympanometry
	10021	Fine Needle Aspiration
	95992	Epley Maneuver

QTY	LAB	
	81015	UA Microscopic
	81000	UA Dipstick
	81025	Urine Pregnancy Test

QTY	OB CARE	
	59400	Total OB Care (w/2 utz)
	76801 - 76817	Other Fetal Evaluations

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QTY	PODIATRY	
	11720	Debride Nail 1-5
	11055	Trim Skin Lesion
	11721	Debride Nail 6 or more

QTY	CARDIOLOGY	
	93306	Transthoracic Echocardiogram (TTE)
	93000	EKG

QTY	SCREENING	
	45378 – 45382, 45385	Colonoscopy Screening and Tumor/ Polyp Removal
	G0105 or G0121	Colorectal Screening
	84152, 84153, 84165	Prostate Specific Antigen complexed
	52000	Cystoscopy

QTY	HOME HEALTH	
	G0299-G0300	Skilled Nurse Visit (RN or LVN) Evaluation
	52000	Cystoscopy

QTY	MISCELLANEOUS	
	11010	Debride skin at fx site
	11011	Debride skin musc at fx site
	11042	Debride skin tissue 20 SQ CM

	11043	Debride musc/fascia 20 sq cm
	11044	Debride Bone 20 sq
	11045	Debride subq tissue add on
	11046	Debride musc/fascia add on
	11047	Debride bone add on
	11055	Trim skin lesion
	11056	Trim skin lesion 2 to 4
	11057	Trim skin lesion over 4
	11102	Tangntl bx skin single lesion
	11103	Tangntl bx skin single eachsep/additional
	11104	Punch bx skin single lesion
	11105	Punch bx skin each sep/additional
	11106	Incal bx skin single lesion
	11107	Incal bx skin each sep/additional

Referring Provider Signature _____ Date _____
Referring Provider _____ Phone # _____ Fax# _____
Print name

This form does not guarantee payments by Imperial Health Plan of the Southwest, Inc. Responsibility for payment shall be subject to member's eligibility, benefit limitations and the interpretations of benefits under applicable subrogation and coordination of benefit rules. This form is not considered valid if not signed by requested provider. Imperial Health Plan of the Southwest, Inc. requires a copy of this direct referral form to be submitted with the claim for payment. Services must be rendered by an Imperial Health Plan of the Southwest Inc. contracted provider. 2018 07




Imperial Health EZ-Net Portal Provider Guide

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Home Page: <http://ihcog-ezweb2/EZ-NET60/Login.aspx>

Home About us Contact us [Login](#) 


Welcome to the Auth Submission and Claim Inquiry portal for:
Check eligibility, claim status, explanation of payment, submit documents securely, check authorization status quickly.

Imperial Health Holdings Medical Group (IHHMG)
Imperial Health Plan of California (IHPC)
Imperial Insurance Companies (IICTX)
Imperial Insurance Companies, INC (EXAZ)
Imperial Insurance Companies, INC (EXNV)
Imperial Insurance Companies, INC (EXTX)
Imperial Health Plan of Southwest (EXUT)
Lone Star Medical Group (LNSTR)
Health Cosmos of New Mexico (COSNM)
Health Cosmos of Arizona (COSAZ)
Health Cosmos of Nevada (COSNV)


Username

Password

[Forgot Username/Password?](#)



Did you know that you can now use Imperial's New Provider Portal?
Check eligibility, claim status, explanation of payment, submit documents securely, check authorization status quickly.



Imperial Health Holdings Website
<http://imperialhealthholdings.com/>
Imperial Health Plan Website
<https://www.imperialhealthplan.com>
Did you know that you can now use Imperial's New Provider Portal?
Check eligibility, claim status, explanation of payment, submit documents securely, check authorization status quickly.

EZ-NET now supports Internet Explorer versions 9, 10 and 11. Always check with your IT before upgrading Internet Explorer.

Did you know that you can now use Imperial's New Provider Portal?
Check eligibility, claim status, explanation of payment, submit documents securely, check authorization status quickly.

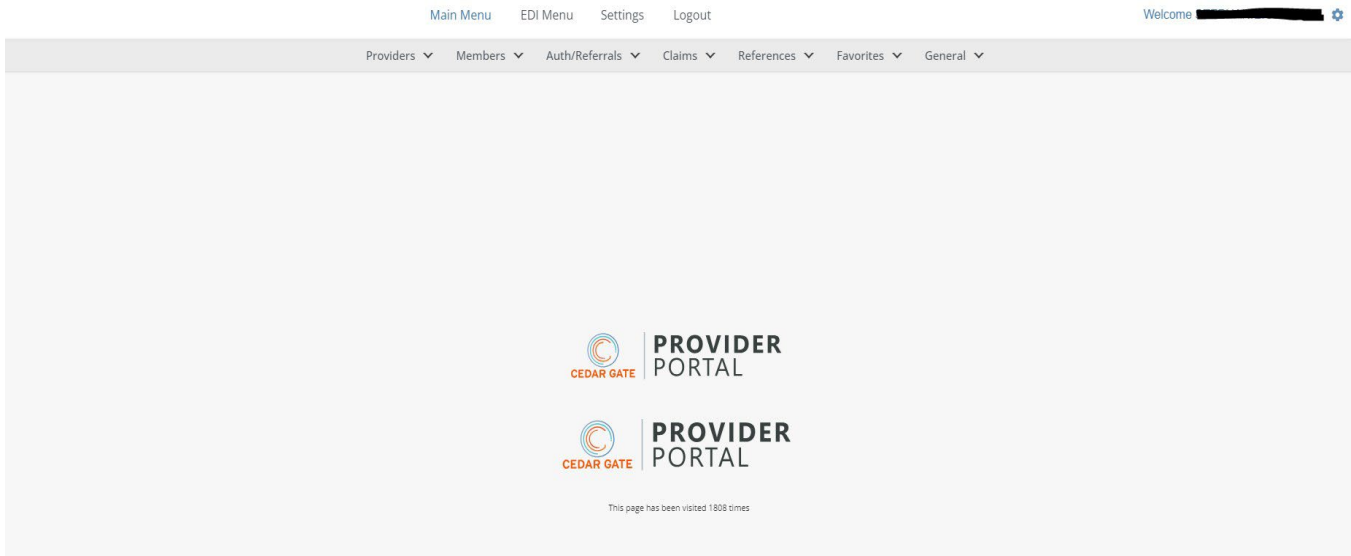
Input your username and password provided by Imperial.

If this is the first time you are logging in, a window will pop up to confirm a valid company email address. (You may bypass this step).

Sign up for the EZ Net Provider Portal here: https://forms.office.com/pages/responsepage.aspx?id=5DmEMBsKOESYLX4BxkC_Z8R0IUAAoydBtDaWxFWfGoxUNThYR1pQNzNVNzMwMEY0RDNYR1JVNjZS-QS4u

Navigate to the ‘**Main**’ menu tab at the top of the page:

On the ‘**Main**’ menu page, you will have access to view **Providers, Members, Auth/Referrals, Claims, References, Favorites, General.**





Providers

Search for a Provider

Click on **Provider Search** in the Providers section of the Main Menu to search for providers. To search for a provider, enter any criteria you wish to narrow the results (or leave all fields empty to search ALL providers) and then click on the button.

EZ-NET will display the search result in the window below, sorted in your specified order (“Sort By” drop-down list). If the system does not locate any records that meet your search criteria, a message stating that “**NO RECORDS FOUND**” will display. Either replace/adjust selection criteria or click on Clear and reenter criteria.

Company ID	Select Company ID. Click on arrow to select from dropdown list. The listing contains multiple company identifications, usually with its acronym followed by its full name.
Provider ID	Provider ID an alpha, numeric or alphanumeric format.
Last Name	Last name of the Physician or the full name of a provider organization.

First Name	First name of the Physician. Note that provider organizations (Such as "Tower Radiology") will not have "first names."
Specialty	Primary specialty of the physician or provider organization. Value defaults to 'None Selected,' which means that the search will not be restricted to a Provider specialty. Searches can be limited to a specific Provider specialty by using the  button.
City	Name of the city in which the Provider's office is located.
Language	n'o can select the Language of the Physician.
Zip	Zip code in which the Provider's office is located.
Service Area	n'o select the Service area of the Physician.
Sort By	n'o specify the presentation order of the search results, click on the Sort By pick list and select one of the following available sort options: Provider Name Specialty City/Name  ity/Specialty City/Zip/Name

Provider Detail

To display provider details, select a provider from the search results list by clicking on the provider name (in **BLUE** text) in search result screen.

Provider Name	Specialty	Group	Phone	Zip	City, State	Language	Company
TEST123S	GYNECOLOGY	SITAM_TEST					CITRA
YY_MM	VENDOR	VENDOR 01 FOR CAPITATION					CITRA
ABC GASTRO	GASTROENTEROLOGY	VALENCIA DISTRICT HOSPITAL	8888888888	91724	COVINA,CA		NICE
FERNANDES DR JAMES	ABDOMINAL SURGERY	MONTANA ENTERPRISES					NICE
HOPKINS ANTHONY	ALLERGY	MONTANA ENTERPRISES					NICE
MEDLINE MEDICAL SUPPLIES	DURABLE MEDICAL EQUIPMENT	MEDLINE MEDICAL SUPPLIES		91101	PASADENA,CA		NICE
PCE	ALLERGY	SOMMER SPECIALTY PRACTICE	7894758962	04401	TEXAS,AK		NICE
RADIOLOGY GROUP	RADIOLOGY	VALENCIA DISTRICT	EEEEEEEEEE	EEEEEAAA	CITY,AK		NICE

By clicking on a provider name, the user can view the Provider Details screen which contains buttons to also view Assigned Members (Eligibility List), Health Plan Affiliations, and Office Locations

Provider Details

Provider Details

Provider ID: 1234567 Company ID: NICE

Provider Name: HOPKINS ANTHONY Class: PRIMARY CARE PHYSICIAN

Practice/ Group: MONTANA ENTERPRISES Group ID: 14334

Address 1: Specialty: ALLERGY

Address 2: Country:

City/ State/ Zip: Contract Effective: 01/01/2020

Phone: Contract Term:

Fax: Contract: CONTRACT W/ BONUS

Service Area:

Additional Information

Field#	User Field	User Field Value	Field#	User Field	User Field Value
1.	UDF#1		2.	UDF#2	
3.	ACCEPTING		4.	VERIFIED	
5.	DATE VERIFIED		6.	NEXT VERIFICATION	

Assigned Members Healthplan Affiliations Office Locations

manager © 2023 Cedar Gate Technologies | Privacy EZ-NET v6.9.0

Click on the Assigned Members, Health Plan Affiliations, and Office Locations buttons, as described in the following section.

Displaying Additional Provider Information

Click on the Assigned members, Health Plan Affiliations, and Office Locations buttons to display additional provider information

To return to the main Provider Detail window, click the [Back to Provider Details](#) button at the bottom of each of the above windows.

Assigned Members

The [Assigned Members](#) button displays member eligibility information for the members that are assigned to that provider. This includes the member's name, birth date, sex, health plan, option, effective date, PCP co-pay, term date, and the company ID for each member. If there are multiple members, there will be a row of this information for each. To return to the previous screen, select the screen name from the top right of the current screen.

Member Name	Birth Date	Gender	Healthplan	Option	Eff Date	PCP Co-Pay	Term Date	Company
PRAJAPATI, ROMY	1/1/1996	FEMALE	NEPA	A	1/1/2020	N/A		NICE
SHRESTHA, PRATIK	1/1/1999	MALE	NEPA	A	1/1/2020	N/A		NICE

Health Plan Affiliation

The **Healthplan Affiliations** button displays the provider's health plan affiliation(s). This information includes the health plan name, effective date, and the termination date for each health plan. If there are multiple health plans, there will be a row of this information for each plan. To return to the previous screen select the screen name from the top right of the current screen.

Home >> Main Menu >> Providers >> Provider Search

Healthplan Affiliation For: MEDLINE MEDICAL SUPPLIES(12345MEDLINE) ?

Healthplan Name	Effective Date	Prov Term Date
cathy and Kelli	1/1/2017	

Page 1 GO of 1 1 Total Item(s): 1 10

[Back to Provider Details](#)

Office Locations

The button **Office Locations** displays the provider's office location including the street, city, state, zip, country, phone, fax, and the office type for each location. If there are multiple locations, there will be a row of this information for each location. To return to the previous screen select the screen name from the top right of the current screen.

Providers Members Auth/Referrals Claims References Favorites General

Home >> Main Menu >> Providers >> Provider Search

Office Location For: SG DR P5(1PROV) ?

Street	City, State	Zip	Country	Phone	Fax	Office Type
NO RECORDS FOUND						

[Back to Provider Details](#)

Members

Search for a Member

Click on **Member Search** in the Members section in the Main Menu to search for members. To search for a member, enter any criteria you wish to narrow the results (or leave all fields empty to search ALL members) and then click on the button.

EZ-NET will display the search result in the window below, sorted in your specified order (“Sort By” drop-down list). If the system does not locate any records that meet your search criteria, a message stating that “**NO RECORDS FOUND**” will display. Either replace/adjust selection criteria or click on Clear and reenter criteria. If member is highlighted in red, this means they have termed. Term date will be on details page.

*Member eligibility is required to be checked with the member’s health plan.

The screenshot shows the 'Member Search' interface. At the top, there are navigation tabs: Providers, Members, Auth/Referrals, Claims, References, Favorites, and General. Below the tabs is a breadcrumb trail: Home >> Main Menu >> Members >> Member Search. The main heading is 'Member Search' with a user icon and help icon. Below the heading is a prompt: 'ENTER YOUR SEARCH CRITERIA BELOW. ANY COMBINATION MAY BE SELECTED'. The search criteria form includes: Company ID (dropdown: All Companies), Member ID (text: 123), PCP ID (text), First Name (text), Last Name (text), Birth Date (dropdown), Address 1 (text), Address 2 (text), City (text), State/Region (dropdown with search icon), Zip (text), Healthplan (dropdown: SELECT HEALTHPLAN), and Sort By (dropdown: MEMBER NAME). There are 'Search' and 'Clear' buttons. Below the form is a table with the following data:

Member ID	Member Name	Gender	Birth Date	Healthplan Name	Healthplan Option	N/E	From Date	Thru Date	PCP ID	PCP Name	Address 1	Address 2	City	St
123	WATSON	MALE	11/13/2015	SENIOR PLAN	SENIOR	<input type="checkbox"/>	11/10/2021	1/23/2023	0007	LAMA PIJA				
123	WOOD, JAMES	MALE	1/1/2000	HEALTHPLAN-UJ	OM-INT	<input type="checkbox"/>	1/1/2020		1010	YELLOW				

To display member details, click on a member ID in the “**Member ID**” column (in **BLUE** text) within the Member Search Results window. The Notes and Memos are displayed based on the PROVIDER ADMINISTRATION PORTAL Company Configurations.

* If the member search returns no results, it does not necessarily mean that the member does not exist. Instead, it could mean that your practice is unable to view the details of members not related to your services. In this case, please call member services to check eligibility.

Pro...ders ▾ Members ▾ Auth/Rererrals ▾ Claims ▾ Rererences ▾ Favorites ▾ General ▾

Home >> Main Menu >> Members >> Member Search

Eligibility - Member Information m ? o

Member Information

Cr,mp,Iny ID	NICE	Member Name:	WATSON
Member ID:	123	Gender:	MALE
DOB	11/13/2019	Age:	3,514YHrS
RelJLION 10 Sub:		Home Phone:	
E-Mail:		Work Phone:	EX**
Address:		Mobile Phone:	
		City/State/Zip:	

Member Benefit Information

Healthplan:	SEN	Benefit Plan:	SENIOR
Employer Group:		Employer Group Desc:	
Benefit Effective:	11/10/2021	Benefit Termed:	01n112021
Benefits Category:	A	New Effective:	<input type="checkbox"/>

PCPOV

Viewing a Member's Authorization History

From the Member Information window, view the member's auth history by clicking on the

Auth History

button to display the Authorization History for Member window.

Home > Main Menu >> Members >> Member Search

Auth History for Member 0

Member	1000	Member Name:	LN 1234567890, FN
ID:	MALE	DOB:	1234567890 01/01/1985
Gender:	38.449 Years		
Age:			

Auth Number	Request	Action Date	Performance Provider	Comp.in
820820127700032500004	Type A	1/27/2022	SIAM	y CITRA

Page 1 of 1 Total Item(s): 1

GO of 10 V

[Back to Member Information](#)

PCP HISTORY

From the Member Information window, view the member's PCP history by clicking on the **"PCP History"** button to display the PCP History for Member window.

This screen displays the PCP information for a member.

Providers ▾ Members ▾ Auth/Referrals ▾ Claims ▾ References ▾ Favorites ▾ General ▾

Home >> Main Menu >> Members >> Member Search

PCP History for Member ?

Member ID: 100 Member Name: TEST EZ-NET
Gender: MALE DOB: 01/01/2000
Age: 23.463 Years

C/H	PCP NPI Number	Provider Name	PCP From	PCP To
C	1265423917	TEST, TEST	3/4/2022	
H	1265423917	TEST, TEST	1/1/2010	3/3/2022

Page 1 GO> of 1 1 Total Item(s): 2 10 ▾

[Back to Member Information](#)

Authorizations & Referrals

Inquiry

To begin an inquiry, select the **Inquiry** option under the Authorization section of the Main Menu to display the “**Authorization/Referral Search**” screen.

EZ-NET PROVIDER PORTAL will display the search result(s) in the window below, sorted in your specified order (“**Sort By**” drop-down list). If the system does not locate any records that meet your search criteria, a message stating that “**NO RECORDS FOUND**” will display. Either replace/ adjust selection criteria or click Clear and re-enter criteria.

NOTE: The Search Results list can be printed by clicking on the ‘**View Report**’ button.

Wednesday, June 14, 2023

PAGE: 1/1

Auth / Referral Report

Auth/Referral Number	Request Type	Status	Memb ID	Member Name	Gender	DOB	Healthplan	Referring Provider	Performing Provider	Company	Priority	HP Auth Number
20230614700052700001	A	APPROVED	M1998	M1998	FEMALE	01/01/1990	H1998	P1998	PRO1998	NICE	0	

AUTHORIZATION DETAILS

From the Auth/Referral Search window, the User can access additional authorization details, member details, and Referring Provider details (in BLUE text in the screen below) by clicking on one of these listed in the Auth/Referral Search results window.

Providers ▾ Members ▾ Auth/Referrals ▾ Claims ▾ References ▾ Favorites ▾ General ▾

Auth/Referral Search

Auth/Referral #:

Requested Date: From: To:

Auth/Action Date: From: To:

Auth Exp Date: From: To:

HP Authorization #:

Member ID:

Status:

Performing Provider ID:

Referring Provider ID:

Auth Priority Status:

Sort By:

Auth/Referral Number	Request Type	Status	Memb ID	Memb Name	Gender	DOB	Healthplan	Referring Provider	Performing Provider	Company	Priority	HP Auth Numbe
20230614700052700001	A	APPROVED	M1998	<u>M1998</u>	FEMALE	1/1/1990	H1998	<u>P1998</u>	<u>PRO1998</u>	NICE	0	

Providers ▾ Members ▾ Auth/Referrals ▾ Claims ▾ References ▾ Favorites ▾ General ▾

Home >> Main Menu >> Auth/Referrals >> Inquiry

Authorization Details

Authorization Information

Authorization # 20230614700052700001

Status: APPROVED

Processed By:

Place Of Service: OFFICE

LDS: 0

Priority Status: 0 - UNSPECIFIED

HP Authorization #:

Request Category:

Service Type:

Decision Date: 6/14/2023

Admit Source:

Facility Code:

Company ID: NICE

Requested Date: 06/14/2023

Time: 11:07:46

Auth Action: 06/14/2023

Determination Date: 06/14/2023

Time: 11:08:22

Expiration Date: 09/12/2023

Authorized Units: 0

Requested Units: 0

Certification Type:

Auth Service Pkg:

Admit Type:

Patient Status:

Patient Information

Patient Name: M1998

DOB: 01/01/1990

Age: 33 YEARS

Gender: FEMALE

Memb ID: M1998

Healthplan: H1998

PCP OV Co-Pay: N/A


Service Area:

Diagnosis Information

Additional Information

Referring Physician Information

To Request an Authorization

Authorization requests can be submitted by the user directly through the PROVIDER ADMINISTRATION PORTAL system. To begin a submission, click **Submission** in the **Auth/Referrals** section of the Main Menu to display the Authorization Submission window. Fill all the required fields and click on the  button to submit the request.

The screenshot shows the 'Authorization Submission Entry' form. At the top, there is a navigation bar with dropdown menus for Providers, Members, Auth/Referrals, Claims, References, Favorites, and General. Below the navigation bar, the breadcrumb trail reads 'Home >> Main Menu >> Auth/Referrals >> Auth Submission'. The form title is 'Authorization Submission Entry'.

Master Record section includes:

- Company ID: NICE - NICE
- Requested Date: 6/14/2023, Time: 11:41:16
- Priority Status: 1 HIGH
- LOS: [Empty]
- Member ID: [Empty]
- Service Area: [Empty]
- Requesting Provider ID: [Empty]
- Service Area: [Empty]
- Requested Provider ID: [Empty]
- Service Area: [Empty]
- Facility ID: [Empty]
- Place Of Service: SELECT A VALUE, From Favorites
- Auth Action: 6/14/2023
- Auth Expiration: 9/12/2023
- Authorized Units: 0
- Healthplan Name: [Empty]
- Name: [Empty]
- Gender: [Empty]
- DOB: [Empty]
- Requesting Provider Name: [Empty]
- Requested Provider Name: [Empty]
- Facility Name: [Empty]
- Requested Units: 0
- Certification Type: [Empty]

Additional Master Info section includes:

- LTR SVC REQUESTED: [Empty]
- LTR SVC MODIFIED: [Empty]
- MEMB NOTIFY DATE: [Empty]
- MEMB NOTIFY TIME: [Empty]
- MEMB NOTIFY BY MD?: [Empty]
- MD NOTIFY DATE: [Empty]
- MD NOTIFY TIME: [Empty]
- MD NOTIFIED BY?: [Empty]
- REFERRED TO CM?: [Empty]
- CALLER NAME: [Empty]
- CALLER PHONE: [Empty]
- MEDICAL CRITERIA MET: [Empty]
- DAY OF STAY: [Empty]
- INFO SOURCE: [Empty]
- ESTIMATED LOS: [Empty]
- FACILITY DAYS: [Empty]
- DENIAL REASON: [Empty]
- REVIEW DATE: [Empty]
- MEMBER COB: [Empty]
- EZNET: [Empty]

Diagnosis section includes:

- Diagnosis Code: [Empty]
- Add Diag (Only 12 diagnosis codes allowed)

Number	Code	Version	Description	LOINC Code

Authorization Submission Entry

Additional Information

Diagnosis

Diagnosis Code:

I10



X

Diagnosis Code Search

Search Clear No of Records: 1 Ok Cancel

Diagnosis Code: I10 Description:

Version:

Begins With Contains From Favorites

Code	Description	From Date	To Date	C/H	Version
I10	ESSENTIAL (PRIMARY) HYPERTENSION	10/11/2015		C	10

Page 1 GO of 1 Total Item(s): 1 50

Auth Action:

Service Requested

Procedure Code:



Auth Procedure Group:



Modifier 1:

SELECT A VALUE

From Favorites

Modifier 2:

SELECT A VALUE

Modifier 3:

SELECT A VALUE

Modifier 4:

SELECT A VALUE

Procedure Code:



Service Type:

PROF

Auth Procedure Group:



Modifier 1:

SELECT A VALUE

From Favorites

Modifier 2:

SELECT A VALUE

Modifier 3:

SELECT A VALUE

Modifier 4:

SELECT A VALUE

Service Line Amount:

Line Rate:

Auth Qty:

1.000

Diag Ref:

1

Admit Date:

Discharge Date:

Number of Days:

0

Admit Type:

Requested Qty:

1.000

Admit Source:

Certification Type:

Request Category:

Facility Type Code:

Service Type:

Add Proc

Additional DI Info	Auth Action	Auth Expiration	Auth Service Type	Description	Mod1	Mod2	Mod3	Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type	Admit Source	Req Qty	Req Catg	Cert Type	Service Type	Fac Type	Service Line Code	Service Line Amount	Line Rate
<input checked="" type="checkbox"/> Additional Detail Info	<input type="text"/>	<input type="text"/>	A1402 P	CARDIAC W/MOTOR >=38.55 & MOTR<	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1.000	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1.000	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Once all the information has been entered and selected, review the data entered the Authorization or Referral Submission Entry form. Submit the form by clicking the button at the bottom of the page. The notification dialog box will display the submission status. To review details of an authorization, click on the line that says “Your authorization or referral number is: #####” to display the Authorization/Referral Details screen.

Please note that all required medical record documents **MUST** be attached to the auth **prior** to submission for review. Authorizations and Referrals submitted **cannot** be modified and a new request will have to be submitted. **CPT codes/quantity adjustments cannot be modified after submission.**

Please ensure that your request is accurate as we must process it as we receive it.

Main Menu EDI Menu Settings Logout Welcome [REDACTED]

Providers ▾ Members ▾ Auth/Referrals ▾ Claims ▾ References ▾ Favorites ▾ General ▾

Service Line Amount: Line Rate:

Auth Qty: Diag Ref:

Admit Date:

Number of Days:

Admit Source:

Request Category:

Service Type:

Discharge Date:

Admit Type:

Requested Qty:

Certification Type:

Facility Type Code:

[Add Proc](#)

X	Additional Dtl Info	Auth Action	Auth Expiration	Auth Proc Grp	ServiceType	Description	Mod1	Mod2	Mod3	Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type	Admit Source	Req Qty	Req Catg	Cert Type	Service Type	Fac Type	Service Line Code	Line Amount	Line Rate
X	Additional Detail Info	▾	▾	A1402	P	CARDIAC W/MOTOR >38.55 & MOTR<					1,000	1	▾	▾			1,000							

Auth Notes [\(Click to Enlarge Notes\)](#)

Submit Request
Clear Form

Turn-Around Times

Urgent: 72 Hours (Medically necessary)

Retro: 30 Days

Claims

Inquiry

The Claim Inquiry screen is where a user can look up claim to inquire on the status of a submitted claim. This will provide claim submission details when the user clicks on one of the claims listed in the table at the bottom of the screen once a search is performed.

To begin an inquiry, click **Inquiry** in the Claims section of the Main Menu to display the Claim Search window.

The screenshot shows the 'Claim Search' interface. At the top, there is a navigation bar with 'Main Menu', 'EDI Menu', 'Settings', and 'Logout'. A 'Welcome' message is partially visible. Below the navigation bar, there are dropdown menus for 'Providers', 'Members', 'Auth/Referrals', 'Claims', 'References', 'Favorites', and 'General'. The main heading is 'Claim Search' with a help icon. Below this, a section titled 'ENTER YOUR SEARCH CRITERIA BELOW. ANY COMBINATION MAY BE SELECTED' contains several input fields: 'Company ID' (dropdown: ALL COMPANIES), 'Status' (dropdown: NONE SELECTED), 'Patient Last Name', 'Auth/Referral#' (with search icon), 'Medical Record#', 'Sort By' (dropdown: CLAIM #), 'Member ID' (with search icon), 'Provider Last Name', 'Patient First Name', 'Provider Patient ID', 'Provider Claim#', 'Claim#' (with search icon), 'Provider First Name', 'Service Date From' and 'To' (date pickers), 'Hosp Patient ID', and 'Cross Reference ID'. 'Search' and 'Clear' buttons are located below the fields. Below the search area is a table header with columns: Claim Number, Member Name, Provider Name, Provider Claim ID, Date Of Service, Status, and Company.

Click on the **Search** button. PROVIDER ADMINISTRATION PORTAL returns the Claim Search Results window, a grid displaying search results sorted in the specified order:

The screenshot shows the 'Claim Search Results' window. It features a 'Search' and 'Clear' button at the top. Below is a table with the following data:

Claim Number	Member Name	Provider Name	Provider Claim ID	Date Of Service	Status	Company
20230614900600100002	9855	9855		1/1/2022	PAID	NICE

At the bottom, there is a pagination control showing 'Page 1 of 1' and 'Total Item(s): 1'. The footer includes '© 2023 Cedar Gate Technologies | Privacy' and 'EZ-MET v6.0.0'.

To display claim detail, click on the selected claim in the **"Claim #"** column (in **BLUE** text) in the Search Results window.

When you want to go back to *the Claim Search Results or Claims* window, use the navigation tool in the top left of the screen by clicking on the name of the screen you want.

The screenshot shows the 'Claim / Encounter Details' window. At the top, there is a navigation bar with dropdown menus for Providers, Members, Auth/Referrals, Claims, References, Favorites, and General. Below this is a breadcrumb trail: Home >> Main Menu >> Claims >> Search. The main content area is titled 'Claim / Encounter Details' and contains several sections:

- Status Information:** A table with fields for Claim#, Auth/Referral#, Date Received, Date Paid, Payment Status, Vender, Payee, Company ID, Status, Provider Claim #, Check, EFT Trace #, Reference #, Claim Type, and Cross Reference ID.
- Patient Information:** Fields for Name, DOB, Gender, and Age.
- Diagnosis Information:** A table with columns for Code, Version, and Description.

The screenshot shows the 'Provider Information' window. It contains several sections:

- Member Information:** Fields for Health Plan, Member ID, Benefit Plan, Prov Pat ID, Address, and Service Area.
- Provider Information:** Fields for Name, Specialty, From Date, Service Area, Provider ID, Place Of Service, and Through Date.
- Additional Information:** A list of fields including DENIAL STATUS CODES, PARENT NAME < 14, PROVIDER NAME, MEMBER LETTER, CONTACT CCS, PDR DECISION, PDR LETTER SENT, and TEST UDF.

To view details of the Member or Provider, click on the link (**NAME** in red text) to display the individual information and detail windows.

Eligibility - Member Information



Member Information

Company ID:	NICE	Member Name:	9855
Member ID:	9855	Gender:	MALE
DOB:	01/01/1990	Age:	33.452 Years
Relation to Sub:		Home Phone:	
E-Mail:		Work Phone:	EXT:
Address:		Mobile Phone:	
		City/State/Zip:	

Member Benefit Information

Healthplan:	BUN	Benefits Plan:	BUN
Employer Group:		Employer Group Desc:	
Benefits Effective:	01/01/2022	Benefits Termined:	
Benefits Category:	A	Never Effective:	<input type="checkbox"/>

PCP OV

Provider Details



Provider Details

Provider ID:	9855	Company ID:	NICE
Provider Name:	9855	Class:	THIS IS CLASS CODE OF UJALA
Practice/ Group:	9855	Group ID:	9855
Address 1:		Specialty:	11
Address 2:		Country:	
City/ State/ Zip:		Contract Effective:	
Phone:		Contract Term:	
Fax:		Contract:	NO CONTRACT
Service Area:			

Additional Information

Field#	User Field	User Field Value	Field#	User Field	User Field Value
1.	UDF#1		2.	UDF#2	
3.	ACCEPTING		4.	VERIFIED	
5.	DATE VERIFIED		6.	NEXT VERIFICATION	

Assigned Members

Healthplan Affiliations

Office Locations

Click on the **DETAIL** link (in the Detail column in the Services Requested table) to view the line-item detail of the Services rendered.

Sequence	Details	Service D	Service C	Description	CPT Mo	Qty	Billed Amt	Cont Amt	Deductible	Deductible E	Deductible F	Copay	Coinsu	WH Am	Adj Am	Net Pal	Adj Grp Co	Adj Codr	Adj Desc	Remitt_Cc	Remitt_Des	
1	DETAIL	1/1/2022	BUN1			1.0	1000.00	1000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1000.00						
2	DETAIL	1/1/2022	BUN1			1.0	2500.00	2500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2500.00						
							Total : \$	\$ 3500	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 3500						
							3500															

Home >> Main Menu >> Claims >> Search

Claim Line Item Details

Status Information

Claim#: 2023061490000100002	Status: PAID
Service Code: BUN1	Check: 43564658
Service Description: BUN1	EFT Trace #:
Service Date: 01/01/2022	Reference #:
Date Paid: 06/14/2023	Mammography Cert #:
Quantity: 1.000	
Billed Amount: \$1000.00	
Contract Amount: \$1000.00	
Deductible: \$0.00	
Deductible Details: \$0.00	
Deductible Adv Rule: \$0.00	
Co-pay Amount: \$0.00	
Co-Insurance: \$0.00	
Withhold Amount: \$0.00	

manager
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EZ-NET v6.9.0

8. My capitation payments I receive from IIC are accurate

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

9. Are my capitation payments paid according to contract rate?

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

Utilization Management

10. UM Representatives are helpful

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

11. Referrals are processed in a timely manner

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

12. Denial notifications consistently provided denial reasons

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

Credentialing

13. The Credentialing process occurred in a timely manner

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

14. Did I receive appropriate notice on need to Re-credential?

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

15. Credentialing Coordinator is courteous and knowledgeable

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

Please provide additional comments or suggestions:

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.



IMPERIAL HEALTH PLAN
OF THE SOUTHWEST

2024 PROVIDER SATISFACTION SURVEY

Please take a few minutes to fill out this survey on the timeliness and quality of the service you receive from Imperial Health Plan of California and FAX it back to 214-452-1190. Thank you for your participation.

ADMINISTRATIVE SECTION

Provider Network Operations

I have been supplied with:

A Provider orientation

YES " NO "

Access to the Web Portal

YES "

NO "

2. My Provider Network Administrator is knowledgeable and able to answer my questions Strongly Agree " Agree " Disagree " Strongly Disagree "

..

3. My Provider Relations Representative responds to my needs or concerns in a timely manner Strongly Agree " Agree " Disagree " Strongly Disagree "

Claims

4. My claims are processed in a timely manner

Strongly Agree " Agree " Disagree " Strongly Disagree "

Claims inquiries are answered promptly

5. Strongly Agree " Agree " Disagree " Strongly Disagree "

6. Are you aware IIC EX accepts electronic claims submission through OfficeAlly? YES " NO "

Capitation

7. My capitation payments are processed in a timely manner.

Strongly Agree " Agree " Disagree " Strongly Disagree "

2. My capitation payments I receive from IIC are accurate

Strongly Agree " Agree " Disagree " Strongly Disagree "

3. Are my capitation payments paid according to contract rate?

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

Utilization Management

4. UM Representatives are helpful

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

5. Referrals are processed in a timely manner

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

6. Denial notifications consistently provided denial reasons

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

Credentialing

7. The Credentialing process occurred in a timely manner

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

8. Did I receive appropriate notice on need to Re-credential?

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

9. Credentialing Coordinator is courteous and knowledgeable

Strongly Agree " **Agree** " **Disagree** " **Strongly Disagree** "

Please provide additional comments or suggestions:

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.
