

SUMMER

2026

# EXCHANGE IMPERIAL PROVIDER NEWSLETTER

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IMPERIAL  
INSURANCE  
COMPANIES



IMPERIAL  
HEALTH PLAN  
OF THE SOUTHWEST

# A MESSAGE FROM OUR CHIEF MEDICAL OFFICER

## DEAR VALUED DOCTORS & NON-PHYSICIAN PRACTITIONER PARTNERS,

Thank you for your continued partnership in delivering high-quality care to our Imperial Exchange members. As we move into the warmer months, we want to share practical strategies to strengthen care for patients with diabetes, hypertension, and related chronic conditions – and to help families stay healthier and avoid serious problems down the road.

Every quality gap is a missed opportunity for preventive care that can avoid the next stroke, the next renal failure, the next vision loss, or the next cardiac event. Gap closure is not about pushing paperwork – with the right mindset, it becomes meaningful clinical care that improves real patient health outcomes.



## KEY HEDIS MEASURES FOR EXCHANGE PLANS —WHAT GOOD CARE LOOKS LIKE

Exchange plans use HEDIS scores to measure quality. Here is what good performance looks like:

- **Blood Pressure Control:** Keep blood pressure below 140/90 for most patients. For patients with diabetes, aim for below 130/80 – and even a systolic below 120 is recommended by the 2025 AHA/ACC guidelines for those with high cardiovascular or kidney risk. The BPROAD trial showed a 21% reduction in major cardiovascular events with intensive BP control in diabetic patients.
- **Diabetes Blood Sugar Control:** Keep A1c below 9% (the HEDIS threshold for "poor control"). The clinical aspiration should be A1c below 7% for most non-pregnant adults, with individualized targets based on patient complexity.
- **Diabetes Eye Exam:** A dilated and comprehensive eye examination by an ophthalmologist or optometrist at least once a year. If no retinopathy is found on one or more exams and blood sugar is at goal, screening every 1–2 years may be appropriate. If any retinopathy is detected, annual dilated exams are required – and if retinopathy is progressing or sight-threatening, referral to an ophthalmologist is essential for evaluation and possible treatment (anti-VEGF, laser photo-coagulation). FDA-approved retinal photography or AI screening programs are acceptable for initial screening but are not a substitute for a dilated comprehensive eye exam.  
**Important:** Rapid, tight glucose control – including with GLP-1 RAs such as semaglutide – can lead to accelerated or early onset of diabetic retinopathy. Ensure a baseline dilated eye exam is completed before or shortly after initiating intensive glycemic therapy in patients with longstanding poorly controlled diabetes.
- **Cancer Screenings:**
  - ✓ **Breast cancer:** Mammogram every 2 years for women ages 40–74
  - ✓ **Cervical cancer:** Screening on time for women ages 21–65
  - ✓ **Colorectal cancer:** Screening for adults ages 45–75
- **Depression Screening:** Screen adults regularly using a validated tool (e.g., PHQ-2/PHQ-9) and follow up with a documented plan if positive.
- **Medication Adherence:** Patients take their important medicines at least 80% of the time (PDC – Proportion of Days Covered).
- **Childhood Immunizations and Well-Child Visits:** High rates of children getting vaccines and regular check-ups on schedule.

These numbers represent real protection for your patients – helping families stay healthier and avoid serious problems down the road.

## KIDNEY HEALTH — CHECK UACR WHEN YOU TEST FOR DIABETES

When ordering labs to evaluate any patient for suspected type 2 diabetes (fasting glucose, A1c), add a spot urine albumin-to-creatinine ratio (uACR) and eGFR at the same time. The ADA recommends uACR screening at the time of type 2 diabetes diagnosis because the onset of type 2 diabetes is difficult to date precisely — many patients already have sub-clinical kidney damage at diagnosis.

**By ordering uACR alongside diagnostic labs, you:**

- Establish a baseline before the diagnosis is even confirmed
- Avoid a return visit
- Ensure no patient falls through the cracks

If uACR is 30 mg/g or higher, confirm with repeat testing within 3–6 months. For patients with confirmed diabetes, check both eGFR and uACR annually.



## ..... GLP-1 RECEPTOR AGONISTS — NOT JUST FOR BLOOD SUGAR .....

For patients with type 2 diabetes and established cardiovascular disease, heart failure, or chronic kidney disease, a GLP-1 receptor agonist with proven cardiovascular benefit (e.g., semaglutide, liraglutide, dulaglutide) should be prescribed — independent of A1c level.

These agents are not just for blood sugar control. A 2025 meta-analysis of 10 major trials (71,351 patients) showed GLP-1 RAs reduce:

- Major cardiovascular events by 14%
- Heart failure hospitalizations by 14%
- Composite kidney outcomes by 17%
- All-cause mortality by 12%

Both injectable and oral formulations provide these benefits. The FLOW trial demonstrated that semaglutide reduced the primary kidney composite outcome by 24% in patients with type 2 diabetes and CKD. CKD progression was slowed by approximately 3 years with GLP-1 RA therapy.

Consider combining a GLP-1 RA with an SGLT2 inhibitor for additive cardiovascular and kidney protection.



**Retinopathy Safety Note:** As noted above, rapid glucose lowering with GLP-1 RAs can worsen pre-existing retinopathy. For patients with known retinopathy or longstanding poorly controlled diabetes, coordinate with ophthalmology before and after initiating therapy.

### **Navigating Prior Authorization for Exchange Plans:**

Exchange plans may have higher step therapy and prior authorization rates than Medicare for these medications. To expedite approval:

- Document the specific cardiorenal indication explicitly (e.g., "Type 2 diabetes with established ASCVD" or "T2D with CKD stage 3, UACR 350 mg/g") — not just "diabetes"
- Document metformin trial or intolerance when step therapy is required
- Build PA submission into the prescribing workflow rather than waiting for a pharmacy rejection
- SGLT2 inhibitors generally face fewer formulary barriers — do not delay SGLT2 inhibitor initiation while awaiting GLP-1 RA PA approval

Imperial is committed to streamlining this process. Our pharmacy team is available to assist with PA submissions. These medications prevent heart attacks, strokes, kidney failure, and death — the administrative effort is worth the clinical outcome.

## WHAT IS ECDS?

ECDS stands for Electronic Clinical Data Systems. It means using information already in your electronic health record (EHR) – such as lab results, blood pressure readings, CGM data, and exam notes – to show the quality of care you provide. Instead of waiting for chart reviews later, good structured documentation during the visit helps close quality gaps in real time. It is not extra work – it is smarter capture of the excellent care you are already delivering.



## TEAM-BASED CARE IS THE KEY TO SUCCESS

We strongly encourage you to redesign your clinic workflows with the goal of better health outcomes for your patients. Ensure all team members – licensed and non-licensed – are working to the top of their professional license. Use automation and smart processes to boost productivity and reduce administrative burden. The end game must always be improved patient outcomes and higher patient satisfaction.

## CONTINUOUS GLUCOSE MONITORING – BETTER DATA, BETTER OUTCOMES, BETTER QUALITY SCORES

Imperial covers continuous glucose monitors (CGMs) for eligible Exchange members with diabetes. CGMs are no longer just for type 1 diabetes – the evidence now supports their use across the full spectrum of type 2 diabetes management.

### What the Evidence Shows:

- CGM use in adults with type 2 diabetes reduces HbA1c by 0.3% on average, with the greatest benefit (up to 1.1% reduction) in patients with baseline A1c of 9% or higher
- Time in range (70–180 mg/dL) increases by 6–15 percentage points – approximately 1.5–3.6 additional hours per day in the target zone
- These improvements occurred without changes in insulin doses – the behavioral insights from seeing real-time glucose data drove the improvement

### The AGP Report – Review It at Every Diabetes Visit:

The Ambulatory Glucose Profile (AGP) is the standardized single-page report that aggregates 14 days of CGM data. Key targets:

- Time in Range (70–180 mg/dL): greater than 70% (approximates HbA1c ~7%)
- Time Below Range (below 70 mg/dL): less than 4%
- Time Below Range (below 54 mg/dL): less than 1%
- Glucose Variability (CV%): 36% or less

### Use the 3-step interpretation approach:

- 1 Check for hypoglycemia first (safety)
- 2 Assess overall time in range
- 3 Identify specific times of day where glucose patterns need intervention.

### GMI and HEDIS – A Game-Changer for Quality Reporting:

NCQA now allows the CGM-derived Glucose Management Indicator (GMI) as an accepted alternative to laboratory HbA1c for HEDIS diabetes quality reporting. This means:

- Patients already on CGM with good control may have an "open" HEDIS gap simply because a lab HbA1c was not drawn – the GMI can close that gap
- For patients with conditions that make HbA1c unreliable (hemoglobinopathies, anemia, CKD, recent transfusion), GMI provides a valid alternative
- Ensure the AGP report is uploaded to the EHR as structured data – a PDF scan alone may not be sufficient for ECDS capture

Important: GMI and lab HbA1c will differ in many individuals. Use them as complementary measures, not interchangeable ones.



# 10 KEY ACTION ITEMS TO IMPROVE PATIENT CARE



**1.** Build a system to identify at-risk patients — Create reliable processes to flag patients who need preventive care, diabetes management, hypertension control, depression screening, or medication adherence.

**2.** Address all related measures during relevant visits — Systematically close every associated quality measure when seeing patients with diabetes or hypertension.

**3.** Prescribe and document evidence-based therapies — Ensure appropriate use of GLP-1 RAs, SGLT2 inhibitors, statins, and RAS antagonists. For patients with T2D and ASCVD, HF, or CKD, prescribe a GLP-1 RA and/or SGLT2 inhibitor independent of A1c. Clearly document clinical reasons when not prescribed.

**4.** Focus on medication adherence — Discuss and document barriers such as cost, side effects, refills, and transportation. Target 80% PDC or higher.

**5.** Document clinical decision-making and ensure accurate encounter submission — Record not just what was done, but the clinical reasoning and outcomes. Use CPT-II codes whenever appropriate — these are not used for direct service reimbursement but are critical for accurately capturing quality performance that drives plan ratings and value-based incentives.

**6.** Prioritize preventive screenings — Complete and document breast, cervical, and colorectal cancer screenings during appropriate visits. Screen for depression using a validated tool and document follow-up plans.

**7.** Prioritize childhood immunizations and well-child visits — Ensure children are up to date on vaccines and receiving regular check-ups on schedule.

**8.** Leverage CGM data for quality reporting — For patients on CGM, download and review the AGP report at every visit. Ensure GMI is captured as structured EHR data to close HEDIS gaps.

**9.** Engage patients in shared decision-making — Help patients understand how closing gaps prevents serious complications like heart attacks, strokes, kidney failure, and blindness. For families, emphasize the importance of keeping children on schedule for vaccines and well visits.

**10.** Partner with Imperial support teams — Refer high-risk patients early to Case Management, Pharmacy, or Disease Management programs.

## AT EVERY APPROPRIATE VISIT, FOCUS ON THE BIG 3

**Blood Pressure** — Repeat elevated readings, document accurately, treat to below 130/80 for diabetic patients (consider SBP below 120 in high CV/ kidney risk). Treat to below 140/90 for most other patients.

**Diabetes** — Address A1c (goal below 7% for most), kidney evaluation (eGFR + uACR), dilated eye exam by ophthalmologist or optometrist, statin, GLP-1 RA/ SGLT2 inhibitor for cardiorenal protection, CGM data review, and adherence. Coordinate with ophthalmology before initiating intensive glycemic therapy in patients with pre-existing retinopathy.

**Medications** — Discuss cost, side effects, refills, and barriers. Target 80% PDC or higher. Proactively submit PA for GLP-1 RAs.

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## FINAL THOUGHT

By redesigning workflows for true team-based care — with every staff member working at the top of their license and leveraging automation, ECDS, and CGM technology — we can achieve what matters most: better health outcomes and higher satisfaction for the patients and families we serve together.

Thank you for your partnership and dedication to outstanding patient care. We are here to support you and your team.

Warm regards,

**Dr. Muthukumar Vaidyaraman**  
MD, MBA, FACHE

Chief Medical Officer

Imperial Health Plan of  
the Southwest & Imperial  
Insurance Companies

# A MESSAGE FROM OUR PHARMACY DEPARTMENT

## PHYSICIAN ADMINISTERED DRUGS (PADS) INFORMATION

Prior authorization is required for all PADs included on the Prior Authorization List. 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. Detailed instructions for submitting a prior authorization request are available in the "Imperial Health EZ-Net Portal Provider Guide" section of this manual. Once a request is received, it will be reviewed for medical necessity utilizing our Medical Necessity review hierarchy. A determination will then be issued via fax within the appropriate turn-around time.

For further information or support, the Utilization Management Department can be reached at 626-838-5100, Hours: M-F 8:00AM-5:00PM PT and 7:00AM-3:30PM PT weekends. Closed on holidays.



### IMMUNIZATION UPDATES

The 2025–2026 COVID-19 vaccines are now available at all pharmacies. Please encourage members to schedule their immunizations today.

The CDC recommends the updated 2025–2026 COVID-19 vaccine for everyone ages 6 months and older, based on individual clinical decision-making, to help protect against potentially serious COVID-19 outcomes during the upcoming season.

Annual influenza vaccinations will also be available this summer to help protect against serious respiratory illness.

Please help us keep our member population healthy and protected this season.

### NOTICE TO PROVIDERS:

#### PHARMACEUTICAL INFORMATION AND UPDATES

We are committed to ensuring that you have easy access to the latest pharmaceutical information to support your practice and patient care. The following resources are available online to help you navigate our pharmacy benefit services effectively:

##### Pharmaceutical information and updates

Pharmaceuticals covered under the pharmacy benefit: information and updates are available on the Provider page of the marketplace website at ([www.imperialhealthplan.com](http://www.imperialhealthplan.com)) as well as in the provider manual. On the provider portal you will be able to access a link to Pharmacy Management that provides:

- Guidance on using pharmaceutical management procedures.
- Instructions for initiating exception requests, including required supporting documentation.
- A prescription written indicating DAW 1 or DAW 2 will not override the subscribers benefit coverage. The subscriber may have a higher out of pocket cost when a Generic Drug is available and the Brand Drug is authorized by their doctor or requested by the subscriber. In these cases, the subscriber will pay the price difference between the Brand Drug and Generic Drug prices in addition to the applicable Copayment or Coinsurance amount.

## PHARMACY BENEFIT UPDATES

Our organization regularly updates pharmacy benefit information to maintain accuracy and relevance. Updates are communicated promptly, within 15 days of receiving notice.

### 2026 Diabetes Supply Recall Alert

Several diabetes-related products have been recalled in 2026 due to potential safety concerns. Please review the following information and follow up with patients using these devices.

**FreeStyle Libre FreeStyle Libre 3 and 3 Plus glucose sensors** – Some sensors may report falsely low glucose readings.

**Omnipod Insulin infusion pump pods** – Internal tubing defects may prevent proper insulin delivery.

**TRUE METRIX Blood glucose monitoring systems** – Instructions may not clearly warn patients to seek medical attention when receiving an E-5 error with symptoms of hyperglycemia.

Healthcare providers are encouraged to verify that patient equipment is functioning properly and that patients understand when to seek medical attention.

## FEEDBACK AND REPORTING

To maintain the quality and accuracy of our pharmacy benefit information, we encourage you to report any inaccuracies or provide feedback on the clarity and usefulness of this information.

Please contact the Imperial Pharmacy Department at (626) 788-0178 with your feedback or concerns.

If you require a written copy of any of this information, it can be requested by calling Member Services: Member Services: (800) 595-0619 (TTY: 711) October March 31: Monday - Sunday from 8:00 am - 8:00 pm and April 1 - September 30: Monday - Friday from 8:00 am - 8:00 pm.

Thank you for your continued dedication to providing high-quality care to our members. Together, we can ensure a healthier future for our communities!

Give us a call, fax, or email if you have any questions. It is our pleasure to assist you.

- Phone (626) 788-0178
- Fax (626) 689-4232
- Pharmacy@imperialhealthplan.com

Sincerely,  
**Imperial Pharmacy Department**

## THE MAIN MARKETPLACE WEBPAGE INCLUDES A DIRECT LINK TO THE DRUG FORMULARY, WHERE YOU CAN FIND:

The Drug Formulary: A list of covered pharmaceuticals with restrictions and preferences (e.g., drug tiers, prior authorization requirements).

You can access the formulary at the following link: <https://client.formularynavigator.com/Search.aspx?siteCode=5261847175> Explanation of quantity limits, generic substitution processes, therapeutic interchange, and step therapy protocols.

For additional questions, please contact MedImpact at 844-269-0977. Their support team is available 24 hours a day, 7 days a week.



# A MESSAGE FROM OUR QUALITY DEPARTMENT

## WHY IT'S IMPORTANT TO SEE YOUR DOCTOR EVERY YEAR

### (Even If You Feel Fine)

Many people who have health insurance through the Exchange (also called the Health Insurance Marketplace) may only go to the doctor when they feel sick. That makes sense—but it's not the best way to stay healthy.

Seeing your doctor once a year for an annual checkup is one of the smartest things you can do for your health. It can help you catch problems early, stay up to date on vaccines, and keep you feeling your best.

## WHAT IS AN ANNUAL CHECKUP?

An annual checkup is a doctor's visit you schedule once a year. It is also called a yearly wellness visit or annual physical.

During this visit, your doctor may:

- Check your blood pressure Ask about your health history
- Talk to you about your diet, sleep, and stress
- Review any medications you take Order lab tests, like blood work
- Make sure you are up to date on screenings

Even if you feel healthy, this visit is still important.

## CATCHING PROBLEMS EARLY CAN SAVE YOUR LIFE

Some health problems do not cause symptoms at first. That means you can have a serious issue and not even know it. Annual checkups can help catch things like:

- High blood pressure
- Diabetes
- Early signs of cancer
- Heart problems

Finding these problems early makes them easier to treat. It can also help prevent them from getting worse.

## PREVENTIVE CARE HELPS YOU STAY HEALTHY

Preventive care means doing things that help prevent illness before it starts.

- At your yearly visit, your doctor might recommend:
  - Flu shots Other vaccines
  - Mammograms (breast cancer screening)



## WHY ADOPT CPT-II CODES IF THERE'S NO REIMBURSEMENT??

1

**Improve Patient Care:** CPT-II codes enable precise tracking of quality measures, helping identify gaps in care and improving outcomes for chronic conditions like diabetes and hypertension.

2

**Streamline Reporting:** These codes simplify compliance with regulatory requirements, saving time and effort in quality reporting processes.

3

**Prepare for Value-Based Care:** As healthcare shifts toward value-based models, CPT-II codes position your practice as a leader in quality care, making it future-ready.

4

**Gain Recognition:** Demonstrating commitment to quality metrics can attract valuable partnerships and enhance your reputation in the healthcare community.

### The Bottom Line:

CPT-II codes are an investment in better care, operational efficiency, and long-term success. Don't miss the opportunity to lead the way in healthcare innovation.

## IMPORTANT UM UPDATES:

### Effective May 26, 2026, the print letter function in EZ-Net has been disabled.

To ensure consistency and accuracy, all letters with CMS and NCQA compliant content will now be issued directly by the UM department.

Please note:

- You can still check the status of submitted authorizations in EZ-Net as usual to schedule patients.
- For claims requiring medical records, please upload them using the Document Management function in EZ-Net (same process as authorization requests).

No other functionality in EZ-Net is affected. If you notice any issues, please let us know. Our Provider Portal team and Provider Network Relations team will work with your office to resolve them quickly.

### Redirecting Pre-Service Authorization Requests

To ensure timely processing and avoid delays in patient care, please submit authorization requests to the appropriate entity based on delegation guidelines.

If a request is submitted to our Utilization Management (UM) team but falls under a delegated provider or vendor (FDR), the request will be redirected to the appropriate entity for review. No clinical review will be performed by our UM team for delegated services.

### Behavioral Health Referrals:

Behavioral Health referrals must be submitted directly to our delegated partner, Lucet, for intake and coordination.

Providers will be notified of the redirect and provided with the correct contact information for future submissions.



**Tip:** Submitting requests directly to the appropriate helps prevent delays and ensures faster processing.

### Submitting a Prior Authorization via EZ-NET

**Step 1:** Log in to the EZ-NET Provider Portal

**Step 2:** Go to Main Menu, then go to Auth/Referrals

**Step 3:** Select New Authorization Request

**Step 4:** Select the correct entity/delegated provider to ensure proper routing

**Step 5:** Enter all required member and service details

**Step 6:** Upload supporting documents and submit



**Tip:** Selecting the correct entity and submitting complete information helps avoid delays in patient care and processing.

# UNDERSTANDING THE U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) GUIDELINES

The U.S. Preventive Services Task Force (USPSTF) guidelines are evidence-based recommendations that support preventive care in the primary care setting. Developed by an independent panel of national experts in prevention and evidence-based medicine, these recommendations focus on screenings, counseling services, and preventive medications intended to improve health outcomes and reduce disease burden.

For primary care providers, USPSTF guidelines are a valuable resource because they help inform clinical decision-making, promote consistent delivery of preventive services, and support early identification of health risks. By using these recommendations, providers can better align care with current evidence and help improve patient outcomes through timely prevention and screening.

## Why USPSTF Guidelines Matter

USPSTF recommendations provide primary care providers with evidence-based guidance to support preventive care decision-making. These guidelines help practices:

- ✓ Detect conditions earlier, when treatment is most effective
- ✓ Standardize preventive care delivery
- ✓ Support quality improvement initiatives
- ✓ Align care with nationally recognized standards
- ✓ Enhance patient education and shared decision-making

Recommendations are assigned grades (“A”, “B”, “C”, “D”, or “I” statements) based on the strength of evidence and the balance of benefits and risks. Many preventive services with “A” or “B” recommendations are also tied to coverage requirements and quality performance measures.

Common preventive services addressed by USPSTF recommendations include:

- ✓ Colorectal cancer screening
- ✓ Breast cancer screening
- ✓ Depression screening
- ✓ Diabetes screening
- ✓ Tobacco cessation interventions
- ✓ Cardiovascular disease prevention

## How Often Are the Guidelines Updated?

USPSTF recommendations are reviewed and updated on an ongoing basis as new clinical evidence becomes available. Most topics are reassessed approximately every 3–5 years, although high-impact topics may be updated sooner when significant new evidence emerges.

To support providers in staying current with preventive care recommendations, Imperial Health Plan annually reviews USPSTF guidelines and distributes updates and resources to participating providers as part of its ongoing commitment to quality improvement and evidence-based care.

## Accessing USPSTF Recommendations

Providers can access the full library of current recommendations, clinical summaries, and supporting evidence directly through the official USPSTF website:

[www.uspreventiveservicestaskforce.org/](http://www.uspreventiveservicestaskforce.org/)

The website includes:

- ✓ Current recommendation statements
- ✓ Preventive care topic search tools
- ✓ Draft recommendations open for public comment
- ✓ Clinical summaries and patient education resources

The USPSTF also offers a free prevention task force app, allowing clinicians to stay informed while on the go. Staying informed of USPSTF recommendations helps ensure preventive care practices remain current, evidence-based, and aligned with national standards of care.



# ANNOUNCING OUR CONTRACTED HOSPITALS

## ARIZONA HOSPITALS

ABRAZO HEALTH

CARONDOLET

PHOENIX CHILDREN'S HOSPITAL

SUMMIT HEALTHCARE REGIONAL  
MEDICAL CENTER

LITTLE COLORADO MEDICAL CENTER

PHOENIX CHILDREN'S HOSPITAL

VALLEYWISE HEALTH

TUCSON MEDICAL CENTER

BANNER MEDICAL CENTER

## NEVADA HOSPITALS

DESERT VIEW HOSPITAL

SUNRISE HOSPITAL AND MED CTR LLC

NORTH VISTA HOSPITAL INC

SAINT MARY'S REGIONAL  
MEDICAL CENTER



**If you have any questions,  
contact our Broker Support  
line 866-442-0001**

## TEXAS HOSPITALS

BAPTIST HEALTH SYSTEM

COOK CHILDRENS MEDICAL CENTER

METHODIST DALLAS MEDICAL CENTER

MEMORIAL HERMANN HEALTH SYSTEM

RESOLUTE HEALTH HOSPITAL

ST JOSEPH MEDICAL CENTER

JPS HEALTH NETWORK

THE HOSPITALS OF PROVIDENCE EL PASO

UNIVERSITY HEALTH SYSTEMS

UNIVERSITY MEDICAL CENTER OF EL PASO

UT HEALTH SAN ANTONIO  
MULTISPC & RESEARCH

## UTAH HOSPITALS

COMMONSPIRIT HEALTH  
HOLY CROSS HOSPITALS

ST. MARKS HOSPITAL

TIMPANAGOS MEDICAL

UNIVERSITY HEALTHCARE

LONE PEAK HOSPITALS

OGDEN REGIONAL

MOUNTAIN VIEW HOSPITAL

# SUPPLEMENTAL BENEFITS



## PEDIATRIC DENTAL

- Offered on all Imperial Plans
- Member Portal with dashboard, dentist finder, cost estimator at: <https://www.deltadentalins.com/find-a-dentist/directory-results/?specialty=General+Dentist&network=2ppo>
- Mobile Application available hosted by Delta Dental.



## PEDIATRIC VISION - VSP

- Access to strong provider network.
- Freedom to choose your doctor and eyewear.



# MAINTAIN YOUR ONLINE PROVIDER DIRECTORY INFORMATION

**Maintaining your online provider directory information is essential for consumers and healthcare partners to connect with you when needed.**

Please review your information frequently and let us know if any of your information we show in our online directory has changed.

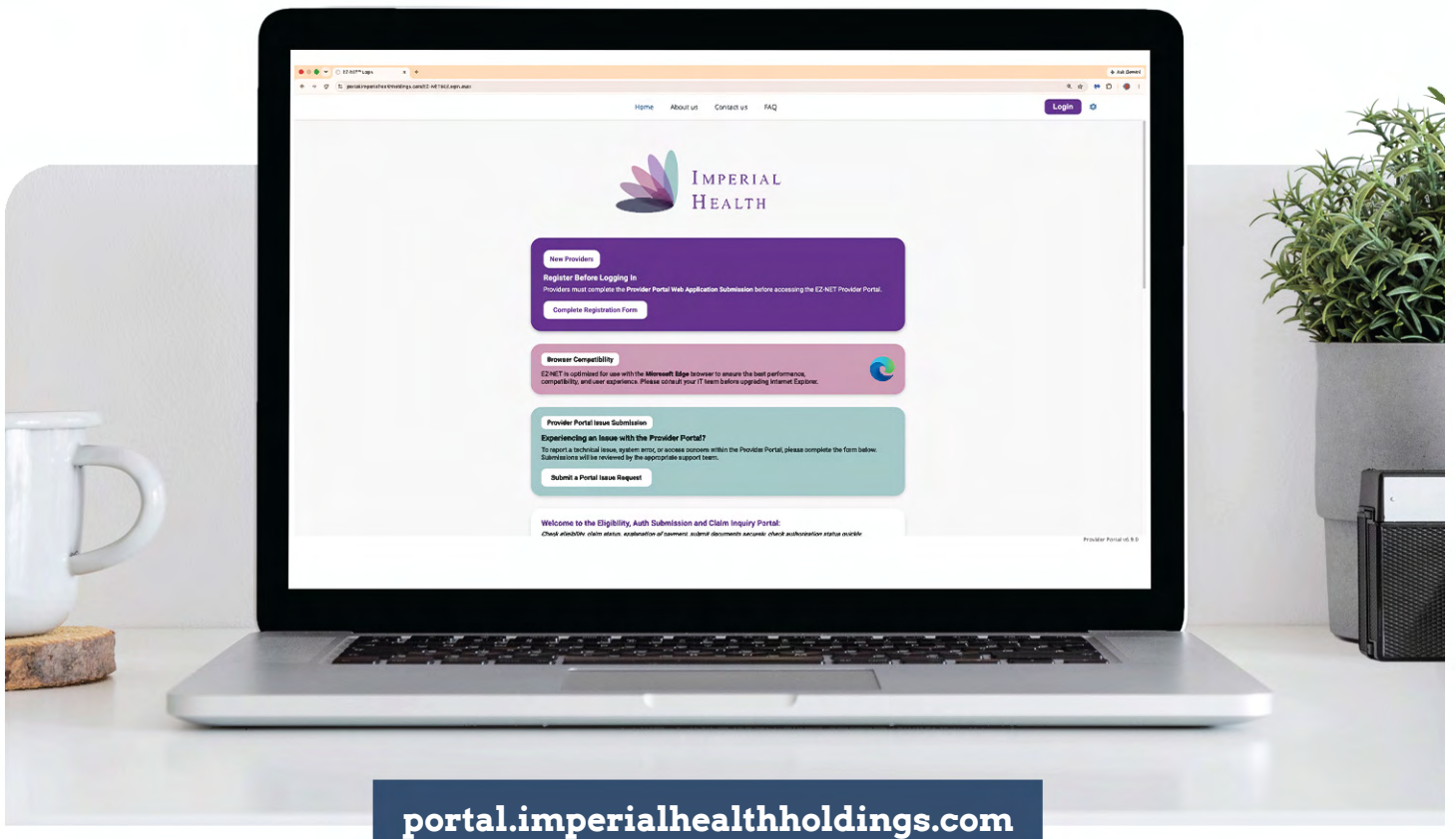
- Add/change an address location
- Add/change billing address
- Add TIN
- Deactivate TIN
- Change TIN

Submit updates and corrections to your online directory information by using our Provider Information Change Request Form, located on our Provider website under “forms”. Once you submit the form, we will send you an email acknowledging receipt of your request. Update options include:

- Name Change
- Provider leaving a group or a single location
- Phone/fax number changes
- Closing a practice location

The Consolidated Appropriations Act (CAA) implemented in 2021 contains a provision that requires online provider directory information be reviewed and updated as needed at least every 90 days. Reviewing your information helps us ensure your online provider directory information is current.

# EZ NET PROVIDER PORTAL



**IMPERIAL IS COMMITTED TO ENHANCING OUR PROVIDER'S EXPERIENCE WITH THE BEST SERVICE POSSIBLE TO SUPPORT THEIR PRACTICE AND ITS DAILY ADMINISTRATIVE NEEDS.**

Imperial is pleased to formally announce the re launch of the IMPERIAL EZ NET PROVIDER PORTAL to all participating network providers.

Urgent authorization requests should be submitted through the Imperial Provider Portal for expedited processing. An expedited/urgent request for a determination is a request in which waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

For example:

- A serious threat to life, limb, or eyesight. Worsening impairment of a bodily function that threatens the body's ability to regain maximum function.
- Worsening dysfunction or damage of any bodily organ or part that threatens the body's ability to recover from the dysfunction or damage; or
- Severe pain that cannot be managed without prompt medical care.

**PORTAL REGISTRATION IS SIMPLE! PLEASE CLICK BELOW!**

[Provider Portal Web Application Submission \(office.com\) Portal Training Request/](#)

Questions:

[pnm@imperialhealthholdings.com](mailto:pnm@imperialhealthholdings.com)

Please allow 3-5 business days for inquiry response

Listening to the needs and requests of providers that utilize our original portal, IMPERIAL has responded with a Secure, User-Friendly Web Platform to allow users effortless, navigation!

- Member Verification of Eligibility Member Lists
- HEDIS Gaps
- Claims Status (detail information) EOP access
- Authorization Submission, Confirmation and Status Provider Search
- Training Modules
- Secure Submission Documents such as W9's, Annual Training Attestation

# MEMBERS RIGHTS & RESPONSIBILITIES

**Our organization annually distributes the Member's Rights and Responsibilities Statement to Providers in the newsletter. Additionally, Providers and Practitioners can find it in the Provider Manual you received upon the orientation process.**

## OUR PLAN MUST HONOR YOUR RIGHTS AS A MEMBER OF THE PLAN

Our plan has staff and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1-800-838-8271  
October 1–March 31: Monday–Sunday, from 8:00 a.m.–8:00 p.m. PST  
April 1–September 30: Monday–Friday, from 8:00 a.m.–8:00 p.m. PST.

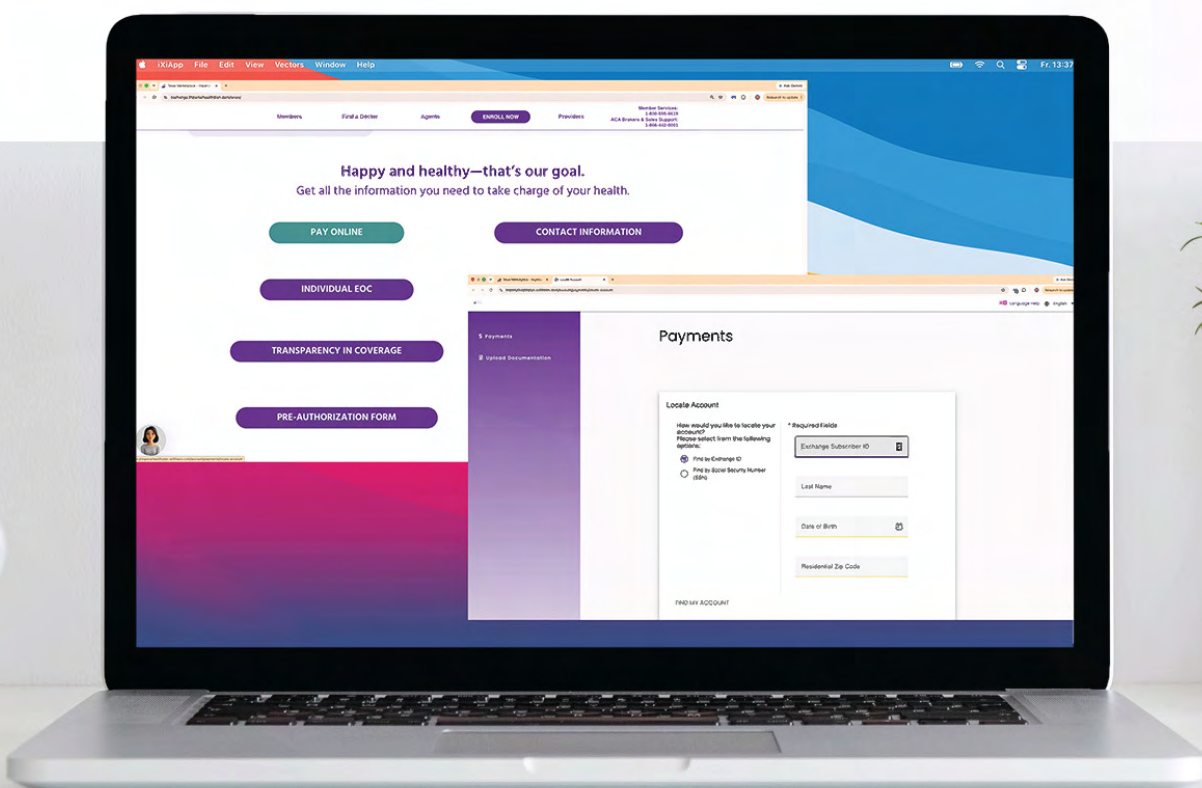
These rights and responsibilities are for all members, regardless of race, sex, culture, economic, educational or religious background. Refer to Chapter 8: Rights and Responsibilities in your **Evidence of Coverage**.

You can locate our Members Rights and Responsibilities on our plan website: [www.imperialhealthplan.com](http://www.imperialhealthplan.com) under "Members", "Member Rights and Responsibilities"

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services at 1-800-838-8271. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Member Services for additional information at the number listed above.

# THE ACA/MARKETPLACE MEMBER PAYMENT PORTAL

Members may now make payments via our online payment portal by visiting [www.imperialhealthplan.com](http://www.imperialhealthplan.com), selecting their state and county from the drop-down menu and then clicking the **"Pay Now"** button.



# PRACTITIONER CREDENTIALING & RIGHTS

**Practitioners are notified of their right to review and correct erroneous information obtained in the credentialing or re-credentialing process. This includes information from any outside primary source (state licensing boards, malpractice insurance carriers).**

The right to review does not extend to references or recommendations or other information is peer review protected or if disclosure is prohibited by law. Before a decision is made, they may also ascertain the status of their application or reapplication at any time by contacting the Credentials Department at:

**Email: [credentialingadmin@imperialhealthholdings.com](mailto:credentialingadmin@imperialhealthholdings.com)**

Practitioners receive notification of their rights by IMAS during the verification process or the appeal process if they do not meet their criteria after receiving a denial or termination of the network during the credentialing/recredentialing process.

If credentialing information obtained from other sources varies from that provided by the practitioner, the credential coordinator will notify the practitioner in writing for their response within ten working days.

The Credentialing Coordinator will make three attempts to collect the corrected information from the practitioner. Telephone, fax, email or letter are all acceptable forms of communication. The credentialing coordinator will advise the practitioner of acceptable formats when submitting corrected information.

Corrected information is accepted by the Credentialing Coordinator and documented in the credentialing system. The practitioner's application is pended until a decision is made by the Credentialing Committee.

The Credentialing Coordinator will date stamp receipt of corrected information and this information is kept in the practitioner's credential file maintained within the department. If the Credentialing Coordinator is unable to obtain the requested information, terminated practitioners can correct discrepant information under the IMAS appeal policy. Practitioners are notified that appeals must be submitted within (30) days.

Practitioners are notified of these rights in the Provider Manual and company website.



# AUTOMATED MEMBER ELIGIBILITY SYSTEM

**DID YOU KNOW IMPERIAL HAS AN AUTOMATED ELIGIBILITY AND BENEFITS LINE AVAILABLE TO ALL PROVIDERS?**

**PROVIDERS MAY VERIFY ELIGIBILITY BY CALLING OUR DEDICATED ELIGIBILITY LINE: (800) 708-7903**

When the automated system asks, “How can I help you?”, simply say “Member eligibility.” You’ll then be prompted to enter your NPI and provide the member’s information verbally. The process is quick and easy.

## Two Easy Ways to Verify Eligibility:

### 1 Automated Member Eligibility System

- » No hold times
- » Fast and user friendly
- » Voice activated
- » Call: (800) 708-7903

### 2 EZ Net Provider Portal

- » You may also continue to verify eligibility through the EZ Net Provider Portal:  
<https://portal.imperialhealthholdings.com/EZ-NET60/Login.aspx>
- » If you do not yet have access, please sign up using the link below: Provider Portal Access Request Form:  
Navigate to [www.imperialhealthplan.com](http://www.imperialhealthplan.com), Providers, Provider Portal Web Application [https://forms.office.com/pages/responsepage.aspx?id=5DmEMBsKOESYLX4BxkC\\_Z8R0IUAAoydBtDaWxFWfGoxUNThYR1pQNzNVNzMwMEYORDNYRIJVNjZSQS4u](https://forms.office.com/pages/responsepage.aspx?id=5DmEMBsKOESYLX4BxkC_Z8R0IUAAoydBtDaWxFWfGoxUNThYR1pQNzNVNzMwMEYORDNYRIJVNjZSQS4u)

We appreciate your partnership and hope these enhancements make your workflow even more efficient.

# EXCHANGE MEMBER GRACE PERIOD NOTIFICATION

**EZ NET ALERT**

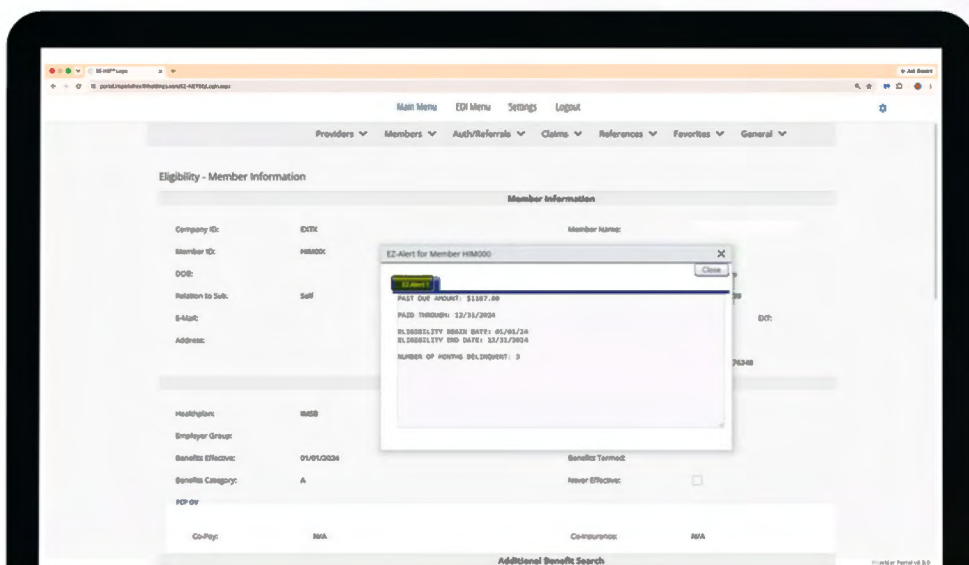
**If a member is delinquent, the provider will receive a pop-up notification when checking eligibility on our EZ Net Provider Portal.**

The Affordable Care Act (ACA) mandates that all qualified health plans offering coverage through the Health Insurance Marketplace, provide a grace period of three consecutive months for APTC subsidized members who fail to pay their monthly premium by the due date. One month of grace period for non-subsidized/APTC members.

## CLAIMS PROCESSING:

Clean claims received for services rendered during the first month of a member's grace period will be processed using Imperials standard processes and in accordance with state and federal guidelines.

Clean claims received during the second and third month of the members grace period can be pended until payment is made for all delinquent months.



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**"WE'RE HERE TO HELP YOU FIND THE  
RIGHT PLAN FOR YOU AND YOUR FAMILY."**