Imperial Health Plan of California, Inc

and

Imperial Health Holdings Medical Group, Inc.

Provider Manual 2024

Imperial Health Plan of California, Inc.
and
Imperial Health Holdings Medical Group, Inc.
Provider Manual 2024

Table of Contents

SECTION 1. INTRODUCTION 6

1.1 Imperial Health Plan of CA, and Imperial Health Holdings Medical Group, Inc. 6

1.2 Quality Management Committee 6

1.3 Provider Relations and Network Operations 6

1.4 Credentialing 7

1.5 Enrollment and Eligibility 7

1.6 Claims and Encounter Data Processing 7

SECTION 2. IMPORTANT CONTACT NUMBERS 8

2.1 Imperial Health Plan of CA Contact Numbers 8

2.2 Other Contact Numbers 8

SECTION 3. RESPONSIBILITIES OF IMPERIAL CONTRACTED PHYSICIANS 9

3.1 Medical Services Covered under Primary Care 9

3.2 Role of Specialty Care Physician 13

3.3 Appointments and Services 14

3.4 Telephone Access 15

3.5 Services for Members with Disabilities 15

3.6 Interpreter Services 15

3.7 Credentialing and Facility Site Review 15

A. Provider Status Change 16

B. Required Reporting 16

3.8 Hospital Admissions and Admitting Staff 16

3.9 Medical Records 16

3.10 Vaccine and Immunization Administration 18

SECTION 4. DATA AND CLAIMS SUBMISSION 20

4.1 Claims Submission 19

SECTION 5. ENROLLMENT AND ELIGIBILITY 21
5.1 Eligibility Verification 21
5.2 Eligibility List 21
5.3 Member Disenrollment 21
5.4 Provider Status Change 21
SECTION 6. REFERRALS 22
6.1 Referral Authorization Process and Guideline 22
6.2 Referral Submission Process for Routine and Urgent Referrals 22
6.3 Guidelines on Authorization Turn-Around Time 23
6.4 Approved Referrals 23
6.5 Denied Referrals 23
6.6 Emergency Room Utilization, Urgent Care and Emergent Referrals 23
SECTION 7. CASE MANAGEMENT PROGRAM 25
SECTION 8. HEALTH RISK ASSESSMENT 25
SECTION 9. NON-COVERED PROGRAM SERVICES 26
9.1 Non-Covered Medicare Advantage Services 26
9.2 Non-Covered Other Lines of business Services 26
SECTION 10. LINKED AND CARVED OUT MEDICARE SERVICES 26
SECTION 11. MEMBER HEALTH EDUCATION AND LANGUAGE ASSISTANCE 28
11.1 Advance Directives 27
11.2 Language Assistance Program 27
SECTION 12. COMPLAINTS AND GRIEVANCES 28
12.1 Member Complaints and Grievances 28
12.2 Physician Complaints 29
12.3 Claims Settlement & Grievance Practices 29
12.4 Member and Provider Satisfaction Surveys 29
SECTION 13. COMPLIANCE 30
13.1 Code of Conduct and Business Ethics 30
13.2 Compliance Program 30
13.3 Fraud, Waste and Abuse Compliance 30
13.4 HIPAA Privacy Practice Notice Guidelines 31
A. Background 31
B. Federal Requirements 31
SECTION 14. QUALITY MANAGEMENT PROGRAM 32

Purpose 32
Scope 34
Goals and Objectives 35
Strategy 36
Communication and Feedback 36
Annual Evaluation and Update of the QM Program 36
Enforcement/Compliance 37
Authority and Responsibilities 37
QMC Structure 38
Pharmacy and Therapeutics (P&T) 39
Utilization Management (UM) 40
QMC Responsibilities 40
QMC Confidentiality Statement 41
Committee Minutes 41
Clinical Practice Guidelines 42
Quality Management (QM) and Improvement (QI) Delegation Oversight 42
Pre-Delegation Assessment / Evaluation 42
Delegation Agreement 43
Communication to Imperial Insurance Companies Providers & Delegates 43
Provider Contracting 43
QM Activities 44
QM Annual Work Plan 44
Coordination of UM and QM Functions Requires review and further clarification 45
QM Process 45
Annual QM Program Evaluation 45
SECTION 15. PROVIDER AND HOSPITAL ROSTER 47
15.1 Laboratory 47
15.2 Radiology/Diagnostic Centers 47
15.3 Contracted Hospital Facilities 47
15.4 PCP and SPECIALIST ROSTER 47
SECTION 16. CLAIMS 48
SECTION 17. OFFICE ALLY & ONLINE SERVICES 53
SECTION 18. PATIENT'S RIGHTS AND RESPONSIBILITIES 54
SECTION 19. FORMS & APPENDICES 56

19.1 General Referral Form

19.2 IHCA Direct Referral Form

19.3 IHHMG Direct Referral Form

19.4 Case Management Referral Form

19.5 EZ-Net Provider Portal Access Request

19.6 EZ-Net Portal Guide

19.7 Provider Satisfaction Survey Enclosed

19.8 Member Satisfaction Survey (only available if disseminated by health plan) Enclosed

19.9 Gap Report Cover Letter

19.10 HEDIS Guide

19.11 Key Contact List

19.12 IHCA Pre-Certification Referral Form

19.13 IHHMG Pre-Certification Referral Form

SECTION 1. INTRODUCTION

1.1 Imperial Health Plan of California, Inc., and Imperial Health Holdings Medical Group, Inc.,

Imperial Health Plan of California, Inc., ("Imperial-HMO") is a health care service plan licensed in California in accordance with the Knox-Keene Health Care Service Plan Act of 1975, as amended with a select network of contracted providers based in numerous counties throughout California. Imperial Health Holdings Medical Group, Inc., ("Imperial-RBO") is a risk-bearing organization licensed in California in accordance with the Knox-Keene Health Care Service Plan Act of 1975, as amended. In the Provider Manual, Imperial-HMO and Imperial-RBO are collectively referred to herein as "Imperial."

Imperial is overseen by an executive board, a Chief Medical Officer and a Quality Management Committee, and other committees that oversee the care provided to Imperial'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 referral requests from providers by processing them within 1-2 working 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 Insurance Companies, Inc. (IIC), 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 Operations

Provider Network Operations (PNO) 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.

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

- Provider Orientation to cover operations for Customer Service, UM, Claims, Eligibility, Imperial rosters, 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 PNO 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) 830-3901

  • 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	(626) 838-5100
Main Fax	(626) 626-521-6028
Eligibility Department	(800) 708-7903

UM Phone	(800) 708-8273 (626) 838-5100
UM Fax	(626) 283-5021 Outpatient Fax (888) 901-2526 Inpatient Fax

Case Management	(800) 708-8273 (626) 838-5100

Claims Department	(800) 778-9302
Claims Forwarding Address	IHPCA: PO Box 60874 Pasadena, CA 91116 IHHMG: PO Box 60075 Pasadena, CA 91116
Claims Payer ID (Electronic Submission)	IHCA Office Ally: IHP01 IHHMG Office Ally: IMMG

Contracting/Provider Services	(800) 830-3901
Contracting/Provider Service Fax	(214) 452-1190

2.2 Other Contact Numbers

PCPs may also contact the Centers for Medicare and Medicaid Services (CMS) for additional information.

MS: For verification of eligibility for Medicare patients and managed care members, call the toll-free line at: (800) MEDICARE or (800) 633-4227.

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 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;
- Miscellaneous supplies related to treatment in PCP's office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies);
- 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.

The following table lists services which are generally considered primary care services. PCPs must have received appropriate training, within the limitations of scope of practice, and consistent with state and federal rules and regulations. The following guidelines are based on routine uncomplicated cases where care is ordinarily provided by a PCP; they are not intended to be all inclusive and should be used with clinical discretion.

Allergies and Immunology	
• Treat seasonal allergies • Treat hives • Treat chronic rhinitis • Allergy history • Environmental counseling	• Minor insect bites/stings • Asthma, active with or without co-existing infection • Allergy testing and institute immunotherapy (if appropriately trained) • Administer immunotherapy
Adult Cardiology	
• Perform electrocardiograms. • Interpret electrocardiograms. • Evaluate chest pain. • Evaluate and treat coronary risk factors, including smoking, hyperlipidemias, diabetes, hypertension	• Evaluate and treat uncomplicated hypertension, CHF, stable angina, non-life-threatening arrhythmias • Evaluate single episode syncope (cardiac) • Evaluate benign murmurs and palpitations

Dermatology	
• Treat acne (acute and recurrent) • Treat painful or disabling warts with topical suspensions, electrocautery, liquid nitrogen. • Diagnose and treat common rashes including: contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor • Screen for basal or squamous cell carcinomas. • Biopsy suspicious lesions (if trained may do biopsy of suspicious lesions for cancer or others such as actinic keratoses) • Punch biopsy • Incisional biopsy	• Diagnose and treat common hair and nail problems and dermal injuries. • Common hair problems include: fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects • Common nail problems include: trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails • Dermal injuries include: minor burns, lacerations, and treatment of bites and stings • Counsel patients regarding removal of cosmetic (non-covered) lesions. • Identify suspicious moles
Endocrinology	

• Diabetic management, including Type I and Type II, for most patients. • Patient education • Supervision of self-blood glucose monitoring (SBGM) testing • Medication management • Manage diabetic ketoacidosis (DKA) • Manage thyroid nodules (testing, radiological imaging)	• Diagnose and treat thyroid disorders • Identify and treat hyperlipidemia • Diet instruction • Exercise instruction • Provide patient education for osteoporosis risk factors • Identify and treat lipid disorders with diet and/or at least two medications for a minimum of six months
Gastroenterology	
• Diagnose and treat lower abdominal pain • Diagnose and treat acute diarrhea • Occult blood testing • Perform flexible sigmoidoscopy • Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease • Evaluate acute abdominal pain	• Diagnose and treat uncomplicated inflammatory bowel disease • Diagnose jaundice • Diagnose and treat ascites • Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids • Manage functional bowel disease • Manage diagnosed malabsorption syndrome • Manage mild hepatitis A
General Surgery	
• Evaluate and follow small breast lumps in teenagers • Order screening mammograms • Aspirate cysts • Foreign body removal	• Laceration repairs (minor) • Local minor surgery for hemorrhoids • Minor surgical procedures • Diagnose gallbladder disease • Manage inguinal hernia
Geriatrics	
• Diagnose and treat impaired cognition (dementia) • Be familiar with effects of aging on drug distribution, drug metabolism, and drug-drug interaction	• Management of advanced illness including the use of alternative levels of care • Recognition of elder abuse

Obstetrics and Gynecology (OB/GYN)	
• Perform routine pelvic exams and PAP smears • Perform lab testing for sexually transmitted diseases (STDs) • Wet mounts • Diagnose and treat vaginitis and STDs • Contraceptive counseling and management • Normal pregnancy (if physician privileged to deliver)	• Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes • Diagnose irregular vaginal bleeding • Diagnose and treat endometriosis with hormone therapy • Manage premenstrual syndrome with non-steroidal anti-inflammatory hormones and symptomatic treatment
Neurology	

• Diagnose and treat all psychophysiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, radiculopathies, and central nervous system (CNS) disorders • Diagnose and treat tension and migraine headaches • Order advanced imaging procedures (MRI or CT scan at an appropriate anatomic level after an appropriate clinical evaluation and trial of conservative therapy)	• Diagnose and management of syncope • Treat seizure disorders • Manage degenerative neurological disorders with respect to general medical care (e.g., Parkinson's) • Manage stroke and uncomplicated TIA patients • Lumbar puncture • Treat myofascial pain syndromes
Ophthalmology	
• Perform thorough ophthalmologic history including symptoms and subjective visual acuity • Perform common eye related services > Distant/near testing > Color vision testing > Gross visual field testing by confrontation > Alternate cover testing > Direct fundoscopy without dilation > Extraocular muscle function evaluation > Red reflex testing in pediatric patients	• Remove corneal foreign bodies (except metallic) • Treat corneal abrasions • Perform tonometry • Diagnose and treat common eye conditions: > Viral, bacterial, and allergic conjunctivitis > Blepharitis > Hordeolum > Chalazion > Subconjunctival hemorrhage > Dacryocystitis
Orthopedics	
• Treat low back pain and sciatica without neurological deficit • Treat sprains, strains, pulled muscles, overuse symptoms • Treat acute inflammatory conditions • Chronic knee problems • Manage chronic pain problems	• Diagnose and treat common foot problems (ingrown nails, corns/calloses, bunions) • Closed emergency reduction of dislocation (digit, patella, shoulder) • Treatment of minor fractures • Arthrocentesis
Otolaryngology (ENT)	
• Treat tonsillitis and streptococcal infections • Perform throat cultures • Evaluate and treat oropharyngeal infections > Stomatitis > Herpangina > Herpes simplex • Treat acute otitis media • Treat effusion	• Evaluate tympanograms/audiograms • Treat acute and chronic sinusitis • Treat allergic or vasomotor rhinitis • Remove ear wax • Treat nasal polyps • Diagnose and treat acute parotitis and acute salivary gland infections • Treat nasal obstruction (including foreign body) • Treat simple epistaxis

Physical Medicine and Rehabilitation	
• Coordinate care for patients recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist	• Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA, AFO for foot drop
Psychiatry	

• Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)	• Diagnose physical disorders with behavioral manifestation • Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist • Diagnose and manage child, elder, dependent adult abuse, and domestic violence victims

Pulmonology	
• Diagnose and treat asthma, acute bronchitis, pneumonia • Diagnose and treat chronic bronchitis • Diagnose and treat chronic obstructive pulmonary disease	• Manage home aerosol medications and oxygen • Work up possible tuberculosis or fungal infections • Treat opportunistic infection • Order chest x-rays, special views, and CT scans
Rheumatology	
• Diagnose and treat non-articular musculoskeletal problems: > Overuse syndromes > Injuries and trauma > Soft tissue syndromes > Bursitis or tendonitis • Provide steroid injections • Manage osteoarthritis unless there is a significant functional impairment despite treatment	• Diagnose crystal diseases • Perform arthrocentesis • Diagnose and treat rheumatoid arthritis • Diagnose and treat inflammatory arthritic diseases • Diagnose and treat uncomplicated collagen diseases
Urology and Nephrology	
• Diagnose and treat initial and recurrent urinary tract infections (UTIs) • Provide long term chemoprophylaxis • Diagnose and treat urethritis • Explain hematospermia • Initiate evaluation of hematuria • Evaluate incontinence • Evaluate male factor infertility and impotence and treat readily correctable factors	• Diagnose and treat epididymitis and prostatitis • Differentiate scrotal or peri testicular masses from testicular masses • Evaluate prostatism and prostatic nodules • Manage urinary stones • Evaluate and treat renal failure • Placement of urinary catheters • Evaluate impotence • Evaluate male infertility
Vascular Surgery	
• Diagnose abdominal aortic aneurysm • Diagnose and treat venous diseases • Treat stasis ulcers	• Manage intermittent claudication • Manage transient ischemic attacks • Manage asymptomatic bruits
Other	
• Basic life support • Advanced life support • Heimlich maneuver	• Endotracheal intubation • Tracheostomy (emergency) • Cardiopulmonary resuscitation (CPR)

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	• 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	• Providers should use an efficient and effective written or computerized appointment scheduling system, which includes follow-up on canceled appointments.
In-Office Waiting Time	• The waiting time for scheduled appointments should be reasonable and within community standards.
Appointments for Urgent and Routine Primary Care Services	• 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: 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	• Specialists must schedule an appointment for non-urgent, properly authorized referrals within 15 calendar days.
Appointments for Routine Prenatal Care	• 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)	• 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	• 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: 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 in California 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 (855) 886-2901.
- 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. Additionally, PCPs participating in Medicare managed care must

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:

- Provider Profile;
- 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 (NPDBa) 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.

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 providers to maintain systematic records of the patients' continuing medical care. PCPs, specialists, and all other providers who provide services to Imperial members must make medical records available to Imperial upon request.

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

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, and no later than 90 days from when care was rendered. Claims will be processed, and payments made in accordance with the Timeliness Guidelines promulgated pursuant to the CMS Medicare Program. 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 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 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, Medicare Provider number, and 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
- EOMB or 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 address:

Imperial Health Plan of California, Inc.

Claims Department
PO Box 60874
Pasadena, CA 91116-6874

Imperial Health Holdings Medical Group, Inc.

Claims Department
PO Box 60075
Pasadena CA 91116

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

Imperial Health Plan of California Office Ally payer code is: IHP01

Imperial Health Holdings Medical Group Office Ally payer code is: IHHMG

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 government program. Medicare Advantage HMO claims shall be paid in accordance with the prevailing Medicare fee schedule and the claims processing and payment guidelines as established by CMS.

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.

To access Medicare's fee schedule, providers may visit http://www.cms.gov/Medicare/Medicare.html

(Refer to Section 12.3 Claims Settlement & Grievance Practices for information regarding claim disputes).

PROVIDERS MUST SUBMIT ENCOUNTER DATA FOR ALL MEMBER ENCOUNTERS, WHETHER THE ENCOUNTER IS CAPITATED OR FEE FOR SERVICE. FAILURE TO SUBMIT THIS DATA MAY IMPACT REIMBURSEMENT.

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 Medicare 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.

Reminder: Balance billing of any HMO member who is enrolled and eligible for covered services at the time the health care service were provided is expressly prohibited by federal and state law and Imperial's provider agreement.

5.2 Eligibility List

Member eligibility is available on the provider portal at
https://portal.imperialhealthholdings.com/EZ-NET60/Login.aspx.

5.3 Member Disenrollment

After open enrollment occurs, Medicare Advantage members are locked into the Plan of choice for 12 months.

Medicare Advantage SNP members have the option to change Plans on a month-to-month basis. 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. (Refer to the Forms Section 17 for General Referral Form).

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 California or
Imperial Health Holdings Medical Group,
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) 830-3901.

General Referral Form in Section 14 can be used and may be faxed to Imperial's UM Department at (214) 452-1905. 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.

Medicare Part C

Citation from CMS MMCM Chapter 13 Parts C & D Enrollee Grievances, Organization/Coverage Determination and Appeals Guidance 40.10 Processing Timeframes

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
Expedited Pre-Service	72 Hours	17 days
Expedited Part B Drug	24 hours	N/A

**14-day extension if the enrollee requests the extension or if the MA plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. MA plan must notify enrollees in writing if extension is going to be taken and explain the reason for the delay. Note: Part B drug and payment timeframes cannot be extended. See: 42 CFR §422.568(b)(1) and (2).*

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 (800) 778- 9521. 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) 708-8273 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. HEALTH RISK ASSESSMENT

8.1 Health Risk Assessments (HRA)

At enrollment, all Special Needs Members (SNP) are given an HRA Survey in their welcome packet to fill out and return. The SNP population contains the frail elderly with certain chronic diseases who often need help managing their care. The HRA survey is designed to identify at risk members who need assistance caring for their needs, such as:

- Scheduling appointments and reminders of office visits for preventative health and specialized office visits;
- Assistance with transportation;
- Assistance with activities of daily living;
- Education and teaching of chronic diseases;
- Pain management;
- Family dynamics; and
- Coordination of care.

8.2 Individualized Care Plans for SNP (C-SNP and D-SNP)

- Care plans are generated and based upon questions and answers on the HRA survey;
- Each member is scored low, medium, or high acuity to determine the needs of each member;
- Each care plan is tailored to address identified problems, interventions, goals and any barriers to the goals;
- Bi-weekly interdisciplinary team IDT meetings are held to review the SNP member care plans;
- Care plans are sent to each member's PCP and the member for review and their records; and
- Each care plan is updated with any change of condition.

SECTION 9 NON-COVERED PROGRAM SERVICES

9.1 Non-Covered Medicare Advantage Services

The following services are not contractually covered and therefore should not be submitted for referral authorization:

- Services not received from or prescribed, referred, or authorized by Imperial (except in the case of emergency or urgent care);
- Services not specifically included in the Evidence of Coverage and Disclosure (Member Handbook) provided by the Imperial;
- Services rendered prior to the member's eligibility effective date with Imperial or following termination of coverage;
- Hospital or medical services that are not medically necessary as determined by a qualified healthcare professional;
- Cosmetic surgery (breast reconstruction is a covered benefit if following mastectomy or catastrophic disfiguring trauma);
- Experimental services;
- Infertility treatment (refer to member's EOC for limitations); and
- Unauthorized ambulance transportation for a non-emergency situation.

In any case, any questions regarding covered benefits may be forwarded to the UM department for further investigation.

9.2 Non-Covered Other Lines of Business Services

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

SECTION 10. LINKED AND CARVED OUT MEDICARE SERVICES

Below are some of the examples of services that are linked or carved out of 'members' health plan benefits. Imperial will help coordinate these services with the provider and the appropriate public health agency.

For the Medicare Advantage Program:

- Adult ;Day Health Care Services
- Dental Services;
- Optometry Benefits; and
- Prescription Drugs – Medicare Part D.

SECTION 11. MEMBER HEALTH EDUCATION AND LANGUAGE ASSISTANCE

11.1 Advance Directives

An advance directive is a formal document, written in advance of an incapacitating illness or injury, in which one can assign decision making for future medical treatment to a third party. States legally recognize the Durable Power of Attorney for Health Care (DPAHC) as an advance directive for adults.

The responsibility of the PCP is as follows:

1. Provide all members 18 years old and above with the Patient Rights Brochure as generally outlined in Title 22, California Code of Regulations, Section 70707. A copy must be provided to the member at the initial encounter with their PCP.
2. Provide the member with the pamphlet, which addresses advance directives, surrogate decision making, and the foregoing of life sustaining procedures.
3. The PCP may assist members who have questions about an advance directive; however, the PCP may not influence the member in making the decision regarding the member's health care.
4. The PCP must document the medical record upon informing the member of the right to execute an advance directive and must document whether the member has executed an advance directive.
5. When the member executes an advance directive, a signed copy must be maintained in the medical record.
6. If the member does not have a written advance directive but expresses his/her intentions regarding future medical care, the PCP shall clearly document all communications regarding the advance directive issue in the medical record. This information must be available to alternate decision-makers for the member in the event the member subsequently becomes incapable of directing his/her own care.

11.2 Language Assistance Program

Imperial and its contracted providers are required to provide timely access to language assistance services to Limited English Proficient (LEP) members at all points of contact and at no cost to them. Language assistance services include interpreter and translation services provided by trained and competent interpreters and translators.

Providers may access telephonic interpreters for all languages by calling Imperial. Interpreter services are available 24/7. Assistance for members who are deaf, hearing, or speech impaired can be accessed telephonically through the California Relay Service. Face-to-face interpreter services are also available for Imperial members, including members who are deaf, hearing, or speech impaired, by calling Imperial. Face-to-face interpreter services must be requested 7 business days in advance.

Interpreter services at Provider Sites:

- Providers must document the member’s preferred language in the member’s medical record.
- Providers must offer interpreter services to members with LEP or who are deaf, hard of hearing, or speech impaired at no cost to the members.
    - Members are not required to provide their own interpreters or use family members or friends as interpreters. Minors should not interpret for adults. The use of family, friends, and/or minors may compromise the reliability of medical information. Use of these people could also result in a breach of confidentiality or reluctance on the part of the members to reveal personal information critical to their situations.

- Providers and staff who communicate with members in a language other than English or who act as interpreters are encouraged to take a language proficiency test by a qualified agency. At a minimum, providers and staff should document their language capabilities on a self-assessment form. The Healthcare Industry Collaborative Effort (ICE) has developed a self-assessment tool that can help bilingual providers and staff assess and document their bilingual skills. Provider or staff who report limited bilingual skills should not act as interpreters or communicate with patients in a language other than English. In this case, interpreter services should be used.
- Providers must document the request or refusal of interpreter services by an LEP or deaf, hard of hearing, or speech impaired member in the member's medical record.

Translations and Materials in Alternative Format

Members with LEP or with disabilities may request member informing and health education materials in their preferred language or in alternative formats. Alternative formats include audio, Braille and large print. Providers should forward these requests to Imperial. Imperial will use qualified translation service vendors to translate these documents to ensure accuracy and cultural and linguistic appropriateness.

.

SECTION 12. COMPLAINTS AND GRIEVANCES

12.1 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 or www.imperialhealthholdings.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.

12.2 Provider Complaints

Providers are encouraged to aid in the overall quality improvement efforts of the provider network by bringing forth issues

that affect members' care, operational issues, or other service problems.

- Providers can submit a grievance to Imperil by telephone, fax, or letter.
- QM staff will assist in resolving the issue and will forward the complaint or problem to Imperial.
- Providers will receive written confirmation of the outcome of the grievance investigation and the QM committee's findings. Administrative and operational issues will be resolved within five (5) business days. Providers will receive written confirmation of the outcome of the grievance.

12.3 Claims Settlement & Grievance Practices

Provisions under HHS provide for fast, fair, and cost-effective dispute resolution mechanisms for claim disputes. 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 Medicare Advantage Program are processed under CMS regulatory guidelines and shall adhere to the timelines for receipt and response as promulgated.

12.4 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 13. COMPLIANCE

13.1 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:

- Be fair and responsive in serving our customers;
- Always earn and be worthy of our customers' trust;
- Respect fellow employees and reinforce the power of teamwork;
- Demonstrate a commitment to ethical and legal conduct;
- Maintain our business and compliance standards; and
- Continuously strive to improve what we do and how we do it.

13.2 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:

- Articulate and demonstrate imperial insurance companies' commitment to regulatory compliance and legal and ethical conduct;
- Increase the likelihood of preventing, identifying, and correcting non-compliant or illegal conduct;
- Formulate and utilize internal controls to promote compliance with state and federal laws and regulations as well as organizational policies and procedures; and
- 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.

13.3 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:

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

The Fraud and Abuse Awareness and Detection Plan is made available for review in the Compliance Department and is reflected in the Fraud & Abuse Reporting System Policies and Procedures located on the Imperial's website, www.imperialhealthplan.com or www.imperialhealthholdings.com. 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. This includes the CMS requirement that all employees who work for or contract with a Medicare managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) providers and their employees must complete an annual FWA training program.

Imperial has established a Fraud and Abuse Compliance Hotline (hereinafter "Hotline"), which is available to all employees and members 24/7. The compliance department has a system in place to receive, record, respond to, and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees, and First-Tier, Downstream and Related Entities ("FDRs) and their employees.

Employees, members, or any other interested parties may call the hotline to report suspected fraudulent, illegal, or non-compliant behavior affecting Medicare, or any other product line, at Imperial. Imperial will make every effort to maintain the confidentiality of the report and the reporting employee or other individual; however, the identity of the employee may become known or may have to be revealed during the investigation.

The hotline telephone number is (888) 708-5377. For additional compliance information, go to the plan website, www.imperialhealthplan.com and www.imperialhealthholdings.com

Members, Imperial employees, providers, or any other person who feels they may have knowledge of something suspicious

may use this hotline. This hotline will help our members, employees, providers, and purchasers feel secure that their services, money, and equipment are used appropriately. Only callers that leave their name and telephone number will receive a confirmation case number. However, if callers or those that email indicate that they wish to remain anonymous, they will not be contacted.

13.4 HIPAA 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 (45 CFR Part 160-164) requires that:

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.

Source: AHIMA Practice Brief, "Notice of Information Practices" (Updated 11/02)

SECTION 14. 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 p e r f o r m s 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:
  - Evaluation of Previous Year QM Program;
  - QM Program;
  - QM Workplan; and
  - QM Policies& Procedures;
- Review and acceptance of:
  - Preventive health guidelines received from Health Plans;
- Ongoing review of:
  - Health Plan reports;
  - 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;
  - 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 used 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:
  - Complaints;
  - CAHPS 5.0 H Survey results;
  - Other data collected on members' experience with the delegate's services; and
  - 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:
  - Readmission reports;
  - One day length of stay reports;
  - Post-op wound infection referrals;

- 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:
  - Review of health plan audits related to:
    - 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);
    - Availability audits (e.g., a member's ability to contact a provider according to protocols); and
    - 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:
  - Measurable objectives for all projects and activities;
  - Name of person accountable for each activity;
  - Time frame for completion for each activity;
  - Monitoring of previously identified changes, issues, and corrective actions;
  - 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 15. PROVIDER AND HOSPITAL ROSTER

15.1 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

15.2 Radiology/Diagnostic Centers

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

15.3 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.

15.4 PCP and SPECIALIST ROSTER

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

SECTION 16. 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 (626) 708-0333 and select option 3 for claims.

Timely Claims Submission:
Clean claims for Medicare 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 Medicare. 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 IIC, 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 Health Plan of California	Via Mail:	P.O. Box 60874 Pasadena, CA 91116-6874
	Via Clearinghouse: Office Ally Payer Code: IHP01	
Imperial Health Holdings Medical Group	Via Mail:	P.O. Box 60075 Pasadena, CA. 91116-6874
	Via Clearinghouse: Office Ally Payer Code: IHHMG	

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.

Imperial will reject claims without the TIN and NPI, and such claims will not qualify as Clean Claims. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the CMS website at www.cms.gov/Regulations-and- Guidance/HIPPA-AdministrativeSimplification/NationalProvidentStand.

National Drug Codes
Imperial follows CMS guidelines regarding National Drug Codes (NDCs). Providers must submit NDCs as required by CMS.

Claim Format:
The standard CMS required forms and data elements can be found in the CMS claims processing manual located at https://www.cms.gov/manuals/downloads/clm104c12.pdf. 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. Imperial will process the contested notice in accordance with Imperial's contracted provider dispute resolution process described in Section 16.2 above.

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 Medicare Advantage 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 90 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.

Reimbursement
Imperial applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

Surgical Payments
Reimbursement to a surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care.
The following claims payment policies apply to surgical services:

• Incidental Surgeries/Complications: A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by Imperial's medical director regarding whether the proposed complication merits additional compensation above the usual allowable amount.

• Admission Examination: One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- Follow-up Surgery Charges: Charges for follow-up surgery visits are considered to be included in the surgical service charge, and providers should not submit a claim for such visits. Providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

- Multiple Procedures: Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

- Assistant Surgeon: Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies.

- Co-Surgeon: Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or her distinct, operative work by adding the appropriate modifier to the procedure code and any associated add on code(s) for that procedure if both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier "62" added.

Modifiers
Imperial follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Virtual Examiner
Under CMS guidelines, compliance programs are a necessity in today's healthcare arena. With that in mind, Imperial has implemented a software solution which provides increased regulatory oversight in accordance with CMS.

A key regulatory mandate was the implementation of the Correct Coding Initiative edits into claims processing for all Medicaid and Medicare Managed Care Plans. One of the goals of Imperial's compliance program is to focus on areas under government inspection and review. When investigating fraud and abuse, federal and state agents are looking at the following

areas: unbundling, up-coding, medically unnecessary services, duplicate billing, and billing for services not rendered.

Imperial utilizes the *Virtual Examiner*® as a technologically advanced tool for highlighting aberrant billing policies and procedures. Using nationally recognized payment and coding guidelines, *Virtual Examiner*® allows the claims examiner to pend, edit, or deny claim entries.

SECTION 17. OFFICE ALLY & ONLINE SERVICES

Web Portal, Imperial Health Plan of California and Imperial Health Holdings, Website

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 (626) 838-5100, extension 7 (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:

Imperial Health Plan of CA is: IHP01

Imperial Health Holdings Medical Group: IHHMG

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

SECTION 18. 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 19. FORMS & APPENDICES

19.1 IHCA Direct Referral Form

19.2 IHHMG Direct Referral Form

19.3 Case Management Referral Form

19.4 EZ-Net Portal Application

19.5 EZ-Net Portal Guide

19.6 Provider Satisfaction Survey Enclosed

19.7 Member Satisfaction Survey (only available if disseminated by health plan) Enclosed

19.8 Gap Report Cover Letter

19.9 HEDIS Guide

19.10 Key Contact List

19.11 IHCA Pre-Certification Referral Form

19.12 IHHMG Pre-Certification Referral Form

IMPERIAL HEALTH PLAN OF CALIFORNIA

PRECERTIFICATION/REFERRAL REQUEST FORM

Fax request to (214) 452-1905 or to check referral status, please call 1 (800) 708-8273

Date Submitted _____

☐ **STANDARD** ☐ **URGENT**

Referring Provider_____**Phone #**_____**Fax #** _____

☐ **OFFICE** ☐ **AMBULATORY SURGICAL CENTER** ☐ **OUTPATIENT HOSPITAL** **REQUESTED DATE OFSERVICE** _____

☐ **HOME** ☐ **DME** ☐ **INPATIENT/ACUTE** ☐ **REHAB/ LTAC** ☐ **SNF** **SCHEDULED ADMIT DATE** _____

Member Name (full name)_____**Date of Birth** _____

Member ID#_____ ☐ **Other Insurance/Worker'sComp**_____

PCP Name_____**PCP Phone #**

_____

Requested Services

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

Diagnosis

ICD code_____**Dx description**_____**ICD code**_____**Dx description**_____

ICD code_____**Dx description**_____**ICD code**_____**Dx description**_____

Requested Specialist/Provider

Name_____**Specialty** _____

Phone #_____**Fax #** _____

Tax ID#_____**NPI #** _____

Requested Facility

Facility Name_____ **Phone #** _____

Tax ID#_____ **NPI #**

Please Attach Clinicals/Therapy/Prescription/Imaging to support Medical Necessity. Only completed referrals will be processed. Do not combine multiple requests for different specialties in a single fax. This referral is valid only for services authorized on this form. This Referral Form does not guarantee payment by Imperial Insurance Companies. Responsibility for payment shall be subject to member eligibility, benefit limitations, and the interpretation of benefits under applicable subrogation and coordination of benefits rules. As the Primary Care Physician (PCP), I am referring this patient to you for the above treatment. For any other services it will be necessary to obtain an additional referral authorization.

_____

IMPERIAL HEALTH PLAN OF CALIFORNIA

Direct Access Referral Form

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 (Including Behavioral Health)	
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	**OPTHAMOLOGY**	
	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
	UROLOGY	
	52000	Cystoscopy
QTY	**PAIN MANAGEMENT**	
	G0480 – G0483	Drug Test 1-7 Classes, 8-14 Classes, 15-21 Classes, and 22+ Classes
	80307	Drug Test PRSMV Chem Anlyzr

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 each sep/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 Insurance Companies, 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 Insurance Companies requires a copy of this direct referral form to be submitted with the claim for payment. Services must be rendered by an Imperial Insurance Companies contracted provider.

2018 0701

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Direct Access Referral Form

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 (Including Behavioral Health)	
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	**OPTHAMOLOGY**	
	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
	UROLOGY	
	52000	Cystoscopy
QTY	**PAIN MANAGEMENT**	
	G0480 – G0483	Drug Test 1-7 Classes, 8-14 Classes, 15-21 Classes, and 22+ Classes
	80307	Drug Test PRSMV Chem Anlyzr

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 each sep/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 Insurance Companies, 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 Insurance Companies requires a copy of this direct referral form to be submitted with the claim for payment. Services must be rendered by an Imperial Insurance Companies contracted provider. 2018 0701

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Fax form with pertinent medical records and information to:
Telephone #: 1 (626) 655-8820
Fax #: 1 (626) 380-9964

Case Management Referral Form

Date of Referral: | **Telephone #:**

Referring Provider: | **Email:**

Member name: | Date of Birth:

Member address: | Member phone number:

Type of Case Management services needed: (check one)

☐	Case Management

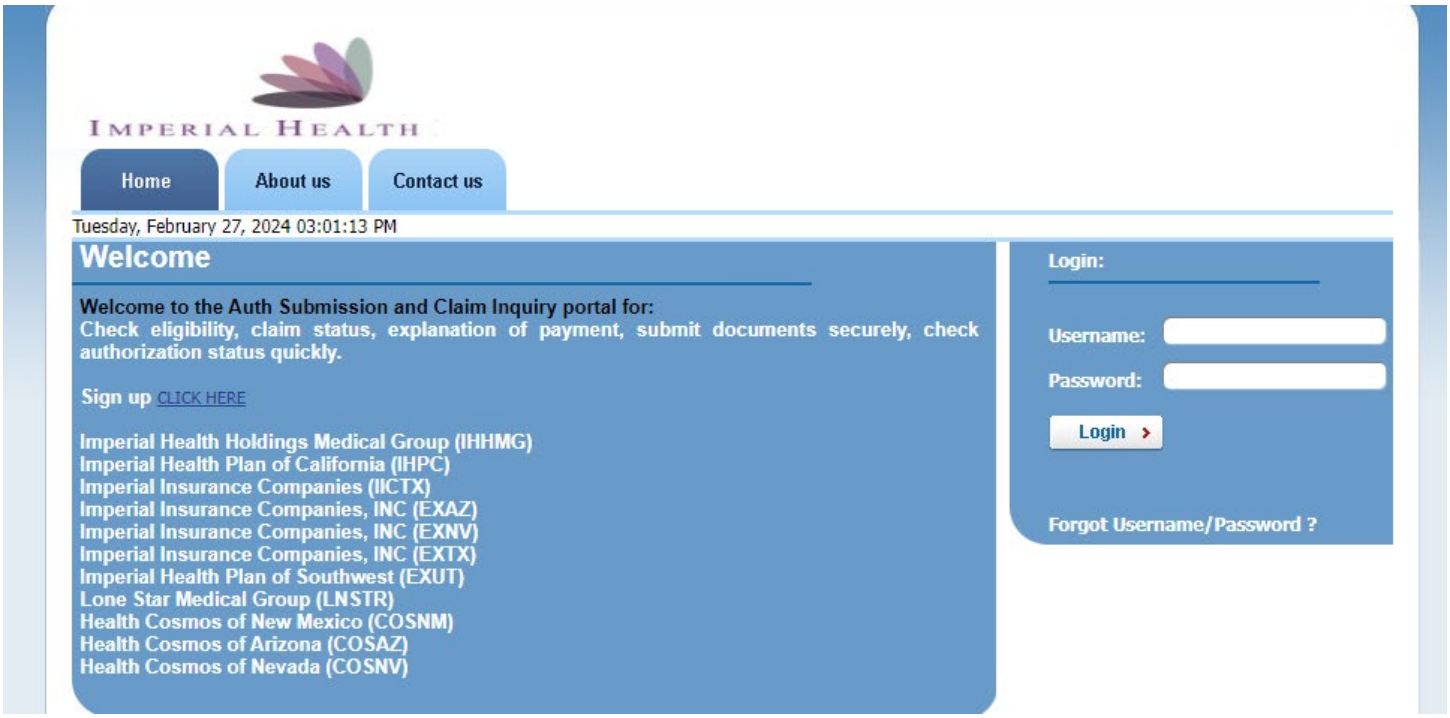
Reason for Case Management Services: (check all that apply)

☐	Difficulty controlling symptoms	☐	Medication or treatment non-compliance
☐	Assistance with self-management	☐	Poly-pharmacy
☐	Assistance with care coordination	☐	Poorly controlled chronic conditions
☐	Multiple hospital admissions or ER visits	☐	Caregiver or social issues

Primary diagnosis:

Additional information:

EZ-NET PROVIDER PORTAL ACCESS REQUEST



To Sign up for our EZ Net Provider Web Portal follow the link below:

https://forms.office.com/pages/responsepage.aspx?id=5DmEMBsKOESYLX4BxkC_Z8R0IUAAoydBtDaWxFWfGoxUNThYR1pQNzNVNzMwMEY0RDNYRlJVNjZSQS4u

Imperial Health
EZ-Net Provider
Portal Guide

Table of Contents

Home Page 3-4

Providers 5

EOB History. 6

Members 7

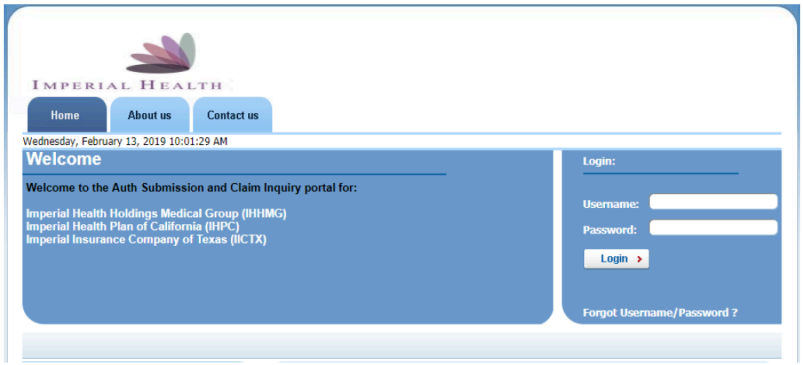
Authorizations/Referrals 8-11

Claims 12-15

References 16

Contacts 17

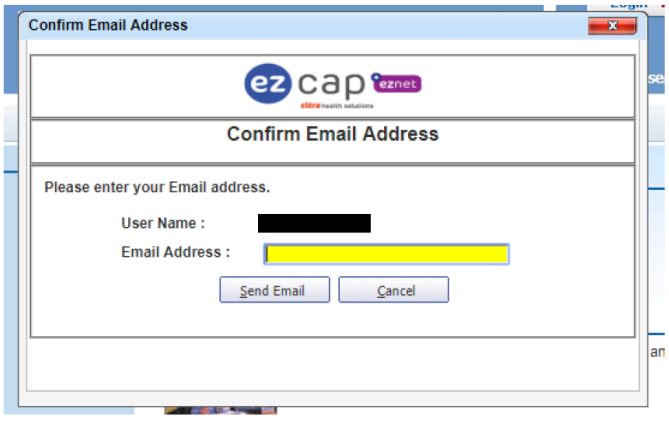
Home Page: https://portal.imperialhealthholdings.com/EZ-NET60/Login.aspx



Input your username and password provided by Imperial.

Only one account will be provided for all staff in your company to use.
Select **Login**.

If this is the first time you are logging in, a window will pop up to confirm a valid company email address. (You can also bypass this window by selecting '**cancel**'.

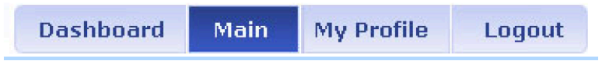


Upon logging in, if you are presented with the following message, you may bypass and continue to the '**Main**' menu tab at the top of the page. The widgets must be configured internally with Imperial and does not prevent the functionality of the portal:

Please Contact Administrator to set your widgets.

Please note the '**My Profile**' tab is <u>not required</u>. That tab is for your own reference on your group and other providers do not see what information is inputted there. Other providers see data that we have on your group from our back end system.

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.**

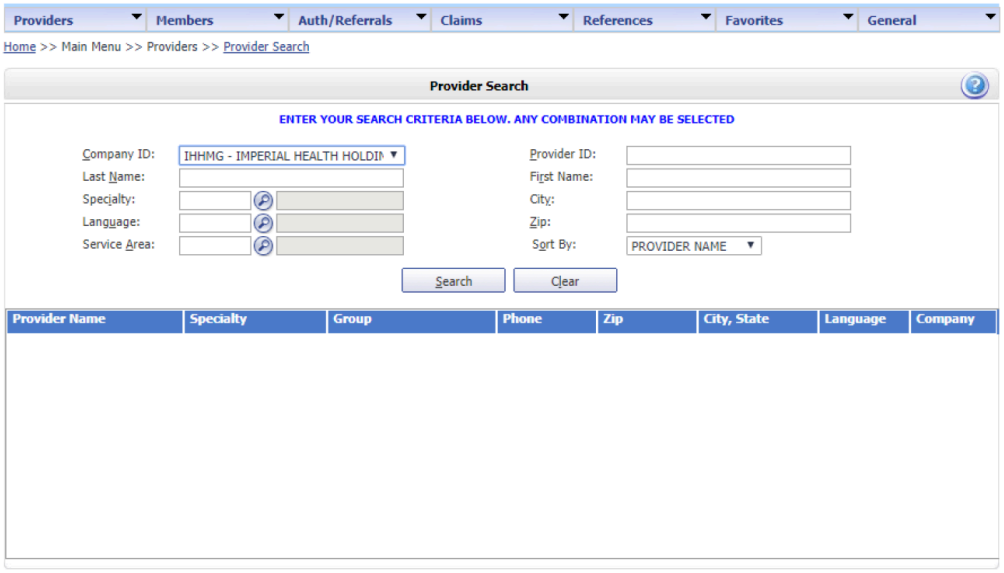
After 30 days, the portal will prompt for a password change. You may continue to use the same password initially given by retyping it in. However, please note that if you change your password entirely, you must inform all your associates who use the portal as well or it will be locked out due to too many failed attempts.

Providers

Search for a Provider

Click on **Provider Search** in the Providers section of the Main Menu to search for providers in **your network operating under the same Tax ID**. 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" dropdown 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.



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.

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.

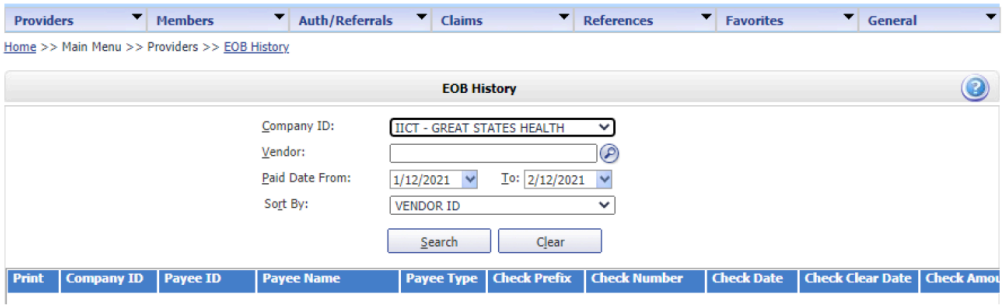
To view all other providers in network with Imperial, you can search via the Auth/Referrals tab when submitting for a member.

EOB History

Search for Explanation of Benefits

Click on **EOB History** in the Providers section of the Main Menu to search for EOB's on file. To search for an EOB, enter the from/to date criteria to narrow the results and hit search.

Each portal account is linked to only **one** Tax ID number. If your group operates under multiple Tax ID's, a new portal application and profile is required for each entity.

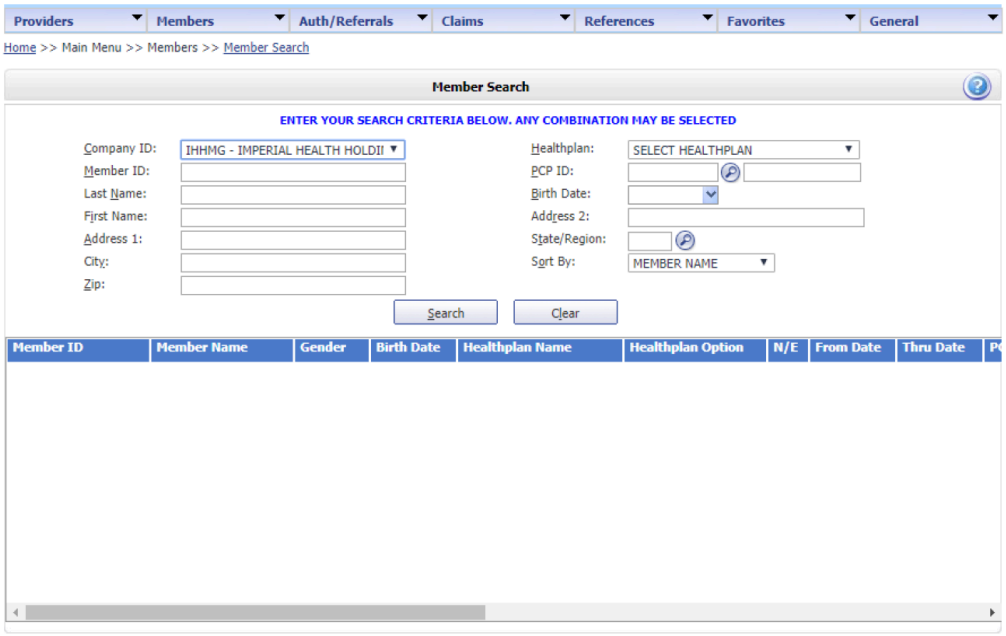


Members

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" dropdown 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.



Member Eligibility

Member eligibility status is required to be checked with the member's health plan directly.
You may also however navigate to the Members>Eligibility tab and search via Member ID.

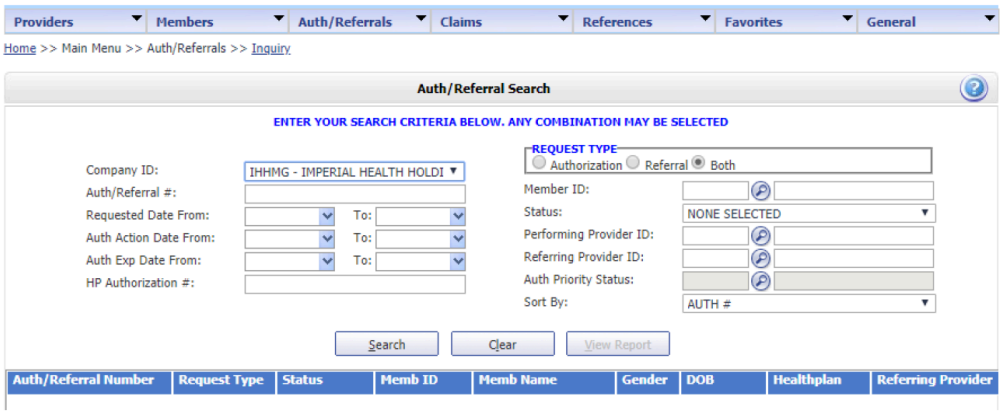
Authorizations & Referrals

Hover the mouse over the **Auth/Referral** tab and select either, '**Inquiry**', '**Auth Submission**' (for Specialists) or '**Referral Submission**' (for PCP).

An EZ-NET user can inquire about an authorization/referral status and view an authorization/referral history.

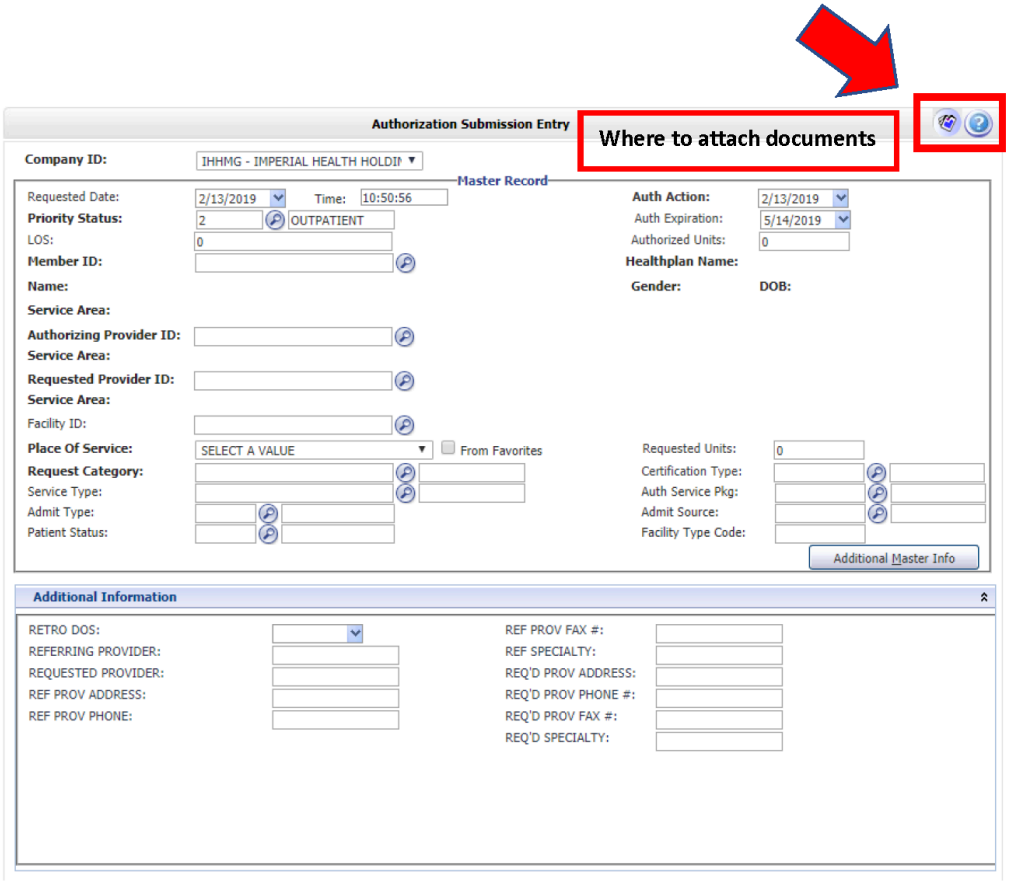
Inquiry

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 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.



Authorizations/Referrals

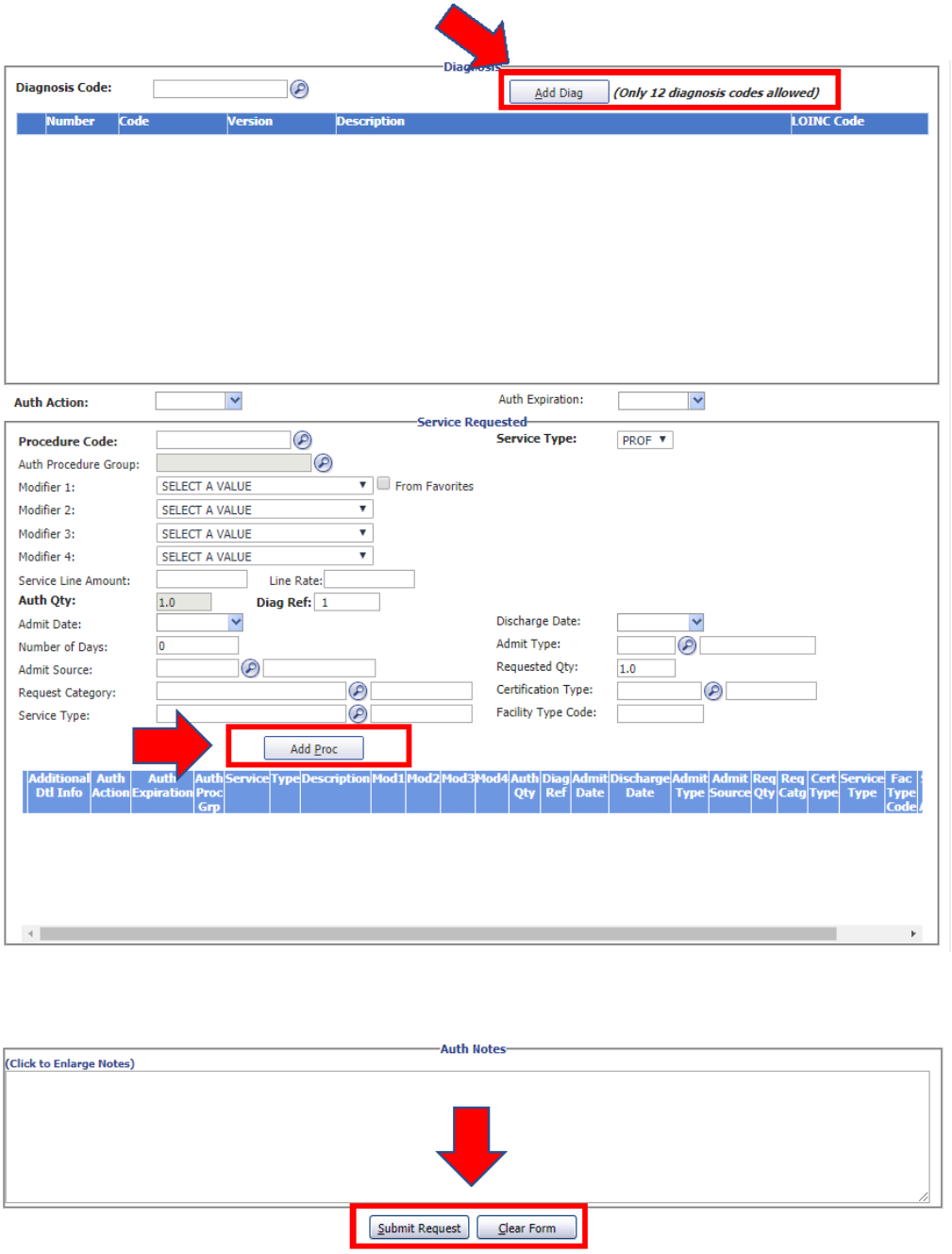
From the Authorization and/or Referral search window, the user can access additional authorization details, referral details, member details, and Referring Provider details.



When the Authorization and/or Referral Details page is displayed, the user may add documents, notes, and memos (**using icons in upper right of screen**) if this has been enabled in EZ-NET Company Configuration (Authorization Details screen shot shown above/below).

Authorization requests can be submitted by the user directly through the EZ-NET system. Prior to submitting an authorization and/or referral, the user may add documents (**using document management icon in upper right of screen**) if this has been enabled in EZ-NET Company Configuration. To begin a submission, click Submission in the Authorization section of the Main Menu to display the Authorization or Referral Submission window (Referral Submission screen shot shown below). Fill in all the required fields and click on the button to submit the request.

Be sure to fill out all required fields in **bold**. If you are not sure of which **contracted** provider to request, please search for '**Unknown Provider**' for submission. (Provider ID: 1316498447).


Diagnosis
Diagnosis Code:
Add Diag
(Only 12 diagnosis codes allowed)
Number
Code
Version
Description
LOINC Code
Auth Action:
Auth Expiration:
Service Requested
Procedure Code:
Service Type:
PROF
Auth Procedure Group:
Modifier 1:
SELECT A VALUE
From Favorites
Modifier 2:
Modifier 3:
Modifier 4:
Service Line Amount:
Line Rate:
Auth Qty:
1.0
Diag Ref:
1
Admit Date:
Discharge Date:
Number of Days:
0
Admit Type:
Admit Source:
Requested Qty:
1.0
Request Category:
Certification Type:
Service Type:
Facility Type Code:
Add Proc
Additional Dtl Info
Auth Action
Auth Expiration
Auth Proc Grp
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 Code

Auth Notes
(Click to Enlarge Notes)
Submit Request
Clear Form

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.

Turn-Around Times

Medi-Cal Standard: 5 Business Days

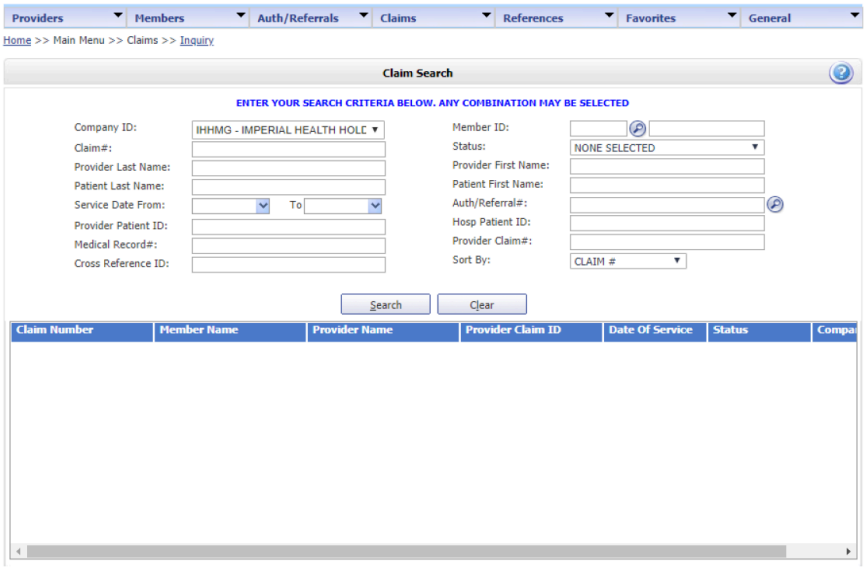
Medicare Standard: 14 Calendar Days

Urgent: 72 Hours (Medically necessary)

Claims

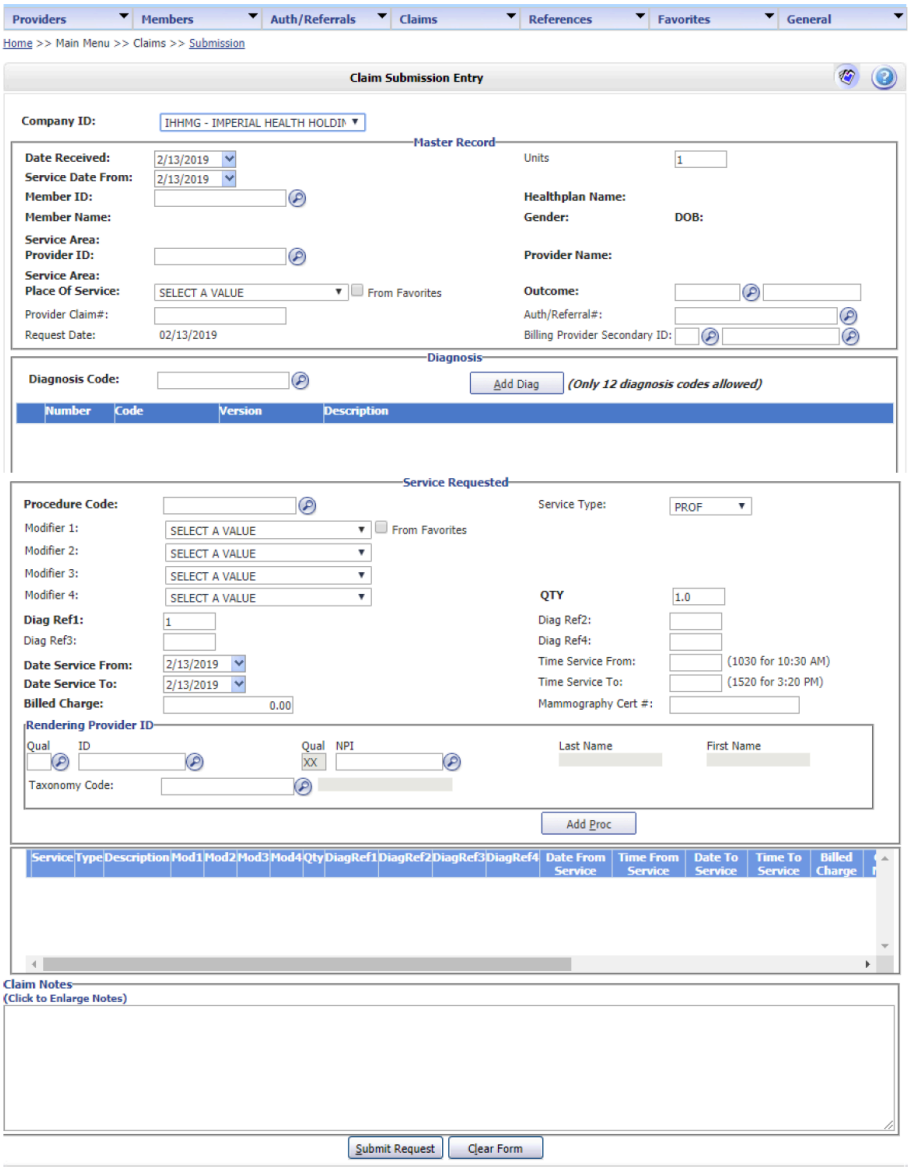
Inquiry

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.



To view an appeal in process, you will follow the same steps as above and will then see two identical claim numbers differentiated by a few digits. One claim is the original and the other is the appeal in process.

Submission Claim requests can be submitted by the user directly through the EZ-NET system. To begin a submission, click Submission in the Claims section of the Main Menu to display the Claim Submission Entry window. Fill in the all the required fields and click on the button to submit the request.



Review data entered the Claim Submission Entry form and then 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 a claim, click on the line that says "Your claim number is: ####################" to display the Claim/Encounter Details screen.

Claims Appeal Submission is not yet enabled. Our claims department requests all appeals to be sent in physically to our corresponding PO Boxes.

Reports

To download a report on claim details, navigate to the '**Reports**' tab under the '**Claims**' tab and change the '**Available Reports**' to either: **Claims Paid by PCP ID, PCP Member, Capitation EOB, Cap Payment.**

P.O. Boxes

All claim mail submissions must be sent to the correct mailing addresses based on company:

Imperial Health Holdings
P.O. Box 60075, Pasadena CA 91116

Imperial Health Plan of California
P.O. Box 60874, Pasadena CA 91116

Imperial Insurance Companies, Inc.
P.O. Box 60160, Pasadena CA 91116

Electronic requests must use Office Ally with Payer ID's: **IHHMG** (IPA), **IHP01** (CA Health Plan), **IICTX** (Texas).

Turn-Around Times

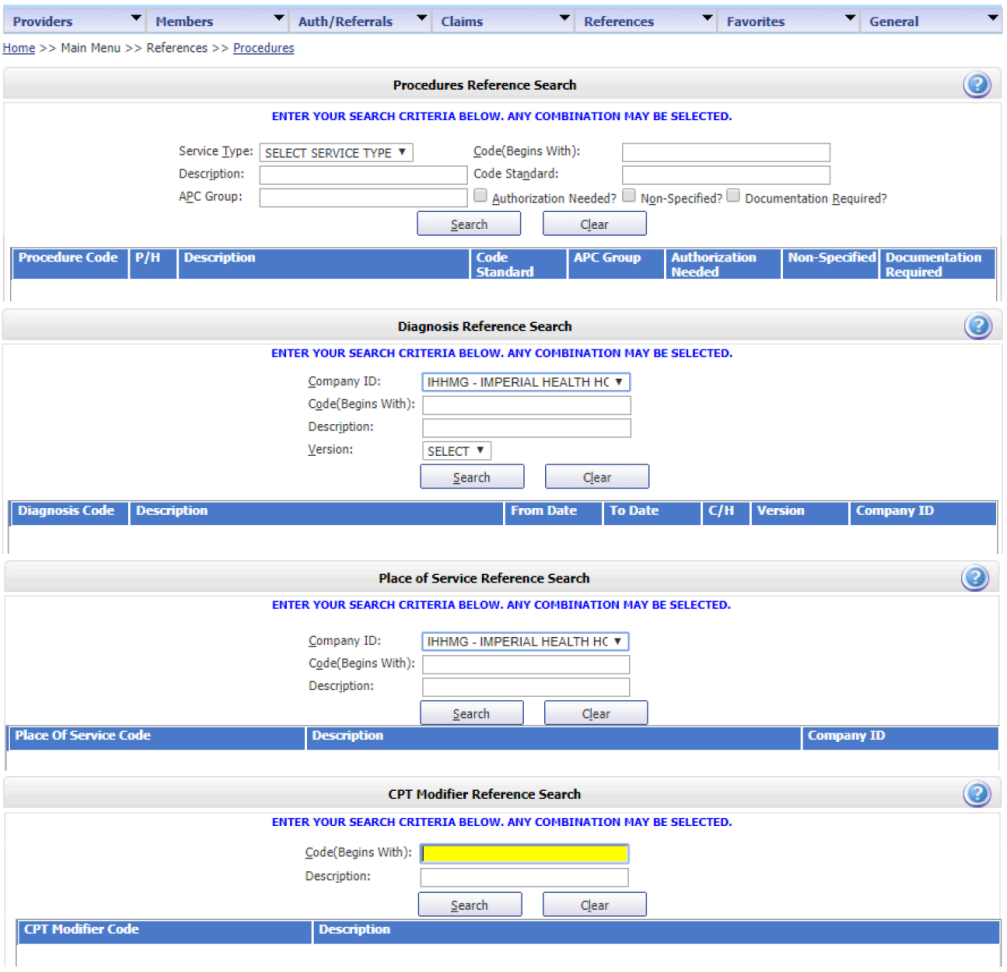
Medicare Non-contracted: 30 Calendar Days Clean Claims
Medicare Non-contracted: 60 Calendar Days Clean Unclean
Medicare Contracted: 60 Calendar Days
Medi-Cal: 30 Calendar Days
Medi-Cal: Provider Dispute Resolution: 45 working
Medicare Non-Contacted Providers: 30 calendar days
Medicare Contracted: Reconsideration-Appeals-Reopening

Medi-Cal:
2 working days of the receipt of an electronic claim
15 working days for the receipt of a paper claim

References

Reference Codes & Contacts

To access EZ-NET system references select one of the following options from within the "**References**" section on the Main Menu: **Procedures, Diagnosis, Place of Service, CPT Modifiers or Contacts**. When you select any of these, a search criteria dialog box will be displayed. For Contacts, use Contact Type = Customer Service.



Contacts

Corporate Office Address:
1100 E Green St, Pasadena CA 91106

Corporate Phone Number:
Imperial Health Holdings Medical Group: (626) 838-5100
Imperial Health Plan of California: (626) 708-0333
Imperial Insurance Companies, Inc.: (626) 708-0333

Corporate Fax Numbers:
Main Fax: (626) 521-6028
Customer Services: (626) 380-9129
Claims: (626) 380-9954
Utilization Management (Outpatient): (626) 283-5021
Utilization Management (Inpatient): (626) 380-9134
Provider Network Operations: (626) 380-9142
Imperial Health Plan (IHP): (626) 205-9536
Imperial Insurance Companies, Inc. (IICTX) PNO: (214) 452-1907

Corporate Extensions:
Utilization Management: Ext 1
Member Services: Ext 2
Claims: Ext 3
Contracting: Ext 4
Provider Services: Ext 5
Eligibility: Ext 6

Customer Service Turn-Around Times:
Voicemail call-backs: 48 Hours

Portal Issues/Concerns:
Provider Network Operations: pno@imperialhealthholdings.com

Imperial Health Plan of California .

Member Satisfaction Survey

1. How long did you wait to get an appointment

To see your primary care doctor †within 1 week †1-2 weeks †3 weeks †4 or more weeks To see a

Specialist †within 1 week †1-2 weeks †3 weeks †4 or more weeks

2. How long did you wait to see your physician once you have arrived at his/her office (past your appointment time?) †0-30 Minutes †30-60 Minutes †More than an hour

3. Was the front office staff courteous to you? †Yes †No

4. Was the back-office staff courteous to you? †Yes †No

5. Was your physician courteous to you? †Yes †No

6. What is your overall satisfaction with the care and service provided through your physician and his/her medical group? †Very satisfied†Satisfied†Dissatisfied

7. Would you recommend your physician to family and friends?†Yes †No

8. How long did you wait to get an answer on your referrals from Imperial Insurance Companies?

†1-3 Days †4-5 days †More than 5 days†Not applicable

9. How satisfied were you with the services provided by your specialist: †Very satisfied†Satisfied† Dissatisfied †Not applicable

10. How satisfied were you with the case management services provided: †Very satisfied†Satisfied† Dissatisfied †Not applicable

11. Did your provider help you regarding your treatment? †Yes†No

12. How long did you wait to resolve your grievance? †within 1 week †1-2 weeks †3 weeks †4 or more weeks†Not applicable

13. How long did you wait to get your claims paid? †within 1 week †1-2 weeks †3 weeks †4 or more weeks†Not applicable

14. Did your provider explain to you about your rights and responsibilities as a Patient?†Yes †No

15. Did your provider give health education materials/referral for your health concern?†Yes †No

16. Did your provider address your cultural and linguistic needs in providing information about your health concern and in providing your referral for other services?†Yes †No

17. Did your provider give you free interpreter information/referral for your health concern?

†Yes †No

Additional comments: _____

Your primary care physician's name: _____

Please return survey to: Imperial Health Plan of California 1100 E. Green St. Pasadena, CA 91106.

Imperial Health Plan of California
PO Box 60874
Pasadena, CA 91116-6874

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 626-283-5022. Thank you for your participation.

ADMINISTRATIVE SECTION

Provider Network Operations

1. 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 IICTX 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 ☐

8. My capitation payments I receive from IICTX 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.

HEDIS 2024 Gaps In Care

Dear Provider,

Attached is your HEDIS 2024 Gaps In Care report, columns marked with “N” indicate that service is required. Please remind and schedule patients to complete their annual wellness visit and refer to the Imperial HEDIS 2024 guide for best practices and coding tips. If the member has already been seen this year and service was completed for columns marked “N” please fax the supporting documentation or medical record to our QI team.

Sincerely,

Quality Improvement & Analytics
E-mail: Quality@imperialhealthplan.com
Fax: 626-380-9121

IMPERIAL
HEALTH PLAN
OF CALIFORNIA

2024 HEDIS Guide

Table of Contents

Initial Health Assessment (IHA) 2
Annual Wellness Visit (AWV) 3
Annual Physical Exam 4
Adolescent Well-Care Visits (AWC) 5
Adult BMI Assessment (ABA) 6
Breast Cancer Screening (BCS) 7
Cervical Cancer Screening (CCS) 8
Controlling High Blood Pressure (CBP) 9
Comprehensive Diabetes Care – HbA1c Control < 8 (CDC) 10
Comprehensive Diabetes Care – Retinal Eye Exam (CDC) 11
Comprehensive Diabetes Care – Nephropathy (CDC) 12
Colorectal Cancer Screening (COL) 13
Medication Reconciliation Post-Discharge (MRP) 14
Transitions of Care (TRC) 14
Medication Adherence 15
Statin Use In Persons With Diabetes (SUPD) 16
Statin Therapy For Patients With Cardiovascular Disease (SPC) 17
Well-Child Visits in the First 15 Months of Life (W15) 18
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) 19

*The listed sample codes are not inclusive and do not represent a complete list of codes

INITIAL HEALTH ASSESSMENT (IHA)

DESCRIPTION	
A comprehensive assessment completed during a newly enrolled member's initial visit with a selected or assigned primary care provider. • IHA must be completed within **120 days** of enrollment and documented in the patient's medical record.	
ICD-10 CODES	
Z00.00, Z00.01, Z00.121, Z00.129, Z00.8	
CPT CODES	
Outpatient	9201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 9391-99397
HCPCS CODES	
Outpatient	G0402, G0438, G0439, G0463, T1015

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Comprehensive history
  - History of present illness
  - Past medical history
  - Review of organ system
- Preventive screening services
- Comprehensive physical and mental status exam
- Diagnosis and plan of care
- Completed Staying Healthy Assessment questionnaire ***required by DHCS**

BEST PRACTICES

1. Review list of newly enrolled patients and call to schedule an appointment
2. Submit timely encounters with proper ICD-10 and outpatient visit codes
   a. ICD-10 code for chronic conditions should be submitted to the highest specificity

Resource	URL

*The listed sample codes are not inclusive and do not represent a complete list of codes

taying Healthy Assessment Tool	ttps://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

*The listed sample codes are not inclusive and do not represent a complete list of codes

ANNUAL WELLNESS VISIT (AWV)

MEDICARE

DESCRIPTION	
Yearly visit to develop or update a personalized prevention plan and perform a health risk assessment.	
ICD-10 CODES	
No abnormal findings	00.00
With abnormal findings	00.01
HCPCS CODES	
Welcome	G0402
Initial	G0438
Subsequent	G0439

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Height, weight, BMI, blood pressure, and other measurementsdeemed appropriate
- Medical and family history
- Assessment of preventable diseases with risk and treatment options
- Assessment of cognitive impairment
- Depression screening
- Updated list of prescriptions and medications
- Health Risk Assessment:
  - Demographic data (*e.g., age, gender, race, ethnicity*)
  - Self-assessment of health status, frailty, and physical function
  - Psychosocial and behavioral health risks
  - Activities of daily living
- Assessment of functional ability and level of safety (*e.g., fall risk, hearing, home safety*)
- Checklist or schedule of preventive screenings for the next 5-10 years

*The listed sample codes are not inclusive and do not represent a complete list of codes

BEST PRACTICES

1. Remind and schedule patients for annual office visits
2. Educate and vaccinate patient for influenza yearly
3. Submit timely encounters with appropriate ICD-10 and HCPCS codes

*The listed sample codes are not inclusive and do not represent a complete list of codes

ANNUAL PHYSICAL EXAM

MEDICAID | COMMERCIAL

DESCRIPTION	
Routine physical checkup with the following requirements: • Record height, weight, and BMI/BMI percentile • Record blood pressure and other vitals as needed • Review medical and family history • Assess risk factors for preventable diseases • Perform head, neck, lung, abdominal, and neurological exam • Test reflexes • Submit urine and blood samples for lab testing (as needed)	
CPT CODES	
New patient	9381-99387
Established patient	9391-99397

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- See description above for documentation requirements

BEST PRACTICES

1. Remind and schedule patients for annual office visits
2. Educate and vaccinate patient for influenza yearly
3. Submit timely encounters with proper coding

*The listed sample codes are not inclusive and do not represent a complete list of codes

ADOLESCENT WELL-CARE VISITS (AWC)

MEDICAID | COMMERCIAL

DESCRIPTION
Patients 12-21 years of age who had one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the year of 2020.

ICD-10 CODES	
Well-Care	00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
CPT CODES	
Well-Care (Ages 12-17)	9384 (new) **or** 99394 (established)
Well-Care (Ages 18-39)	9385 (new) **or** 99395 (established)

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Health history
- Physical exam
- Physical health development
- Immunization history
- Mental health developmental history
- Health education/anticipatory guidance

BEST PRACTICES

1. Identify patients who have not completed their well-care visit and call to schedule an appointment
2. Submit timely encounters with proper coding

*The listed sample codes are not inclusive and do not represent a complete list of codes

ADULT BMI ASSESSMENT (ABA)

DESCRIPTION	
Patients 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented in years 2019 or 2020.	
ICD-10 CODES	
BMI Percentile (Age 18-19)	68.51 - Z68.54
BMI Value (Age 20-74)	68.1, Z68.20-Z68.39, Z68.41-Z68.45
CPT CODES	
Outpatient	9201-99205, 99211-99215, 99241-99245, 99341-99345
HCPCS CODES	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes: *Pregnancy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- For members 20 years of age or older
  - Weight and calculated BMI value
- For members 18-19 years of age
  - Height, weight, and BMI percentile documented as a value

BEST PRACTICES

1. Schedule patients for an annual office visit
2. BMI value/percentile must be calculated and noted in patient's medical record
   - **Documentation of height and weight alone will not satisfy this measure**
3. Submit timely encounters with proper ICD-10 and outpatient visit codes

*The listed sample codes are not inclusive and do not represent a complete list of codes

Resource	URL
Adult BMI alculator	ttps://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html
MI ercentile Calculator	ttps://www.cdc.gov/healthyweight/bmi/calculator.html

*The listed sample codes are not inclusive and do not represent a complete list of codes

BREAST CANCER SCREENING (BCS)

DESCRIPTION
Women 50–74 years of age who had a mammogram to screen for breast cancer between October 2018 and December 2020.
CPT CODES
Mammography 7055-77057, 77061-77063, 77065-77067

***Exclusion codes**: Absence of Left Breast, Absence of Right Breast, Advanced Illness, Bilateral, Mastectomy, Frailty, History of Bilateral Mastectomy, Unilateral Mastectomy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Copy of radiology report and documentation of historic mammogram results with date of service between 10/1/2018 – 12/31/2020

BEST PRACTICES

1. Educate patients on breast cancer prevention
2. Review findings and document history of a mammogram performed within the last 2 years
3. Refer patient to radiologist and schedule for a mammogram
    a. Schedule a follow-up visit with patient to review results
    b. Document completed mammogram in progress notes with date of service and result of the screening

*The listed sample codes are not inclusive and do not represent a complete list of codes

CERVICAL CANCER SCREENING (CCS)
MEDICAID | COMMERCIAL

DESCRIPTION	
Women 21-64 years of age who completed a Pap smear (cervical cytology) in years 2018-2020 **Or** Women 30-64 years of age who had a Pap smear (cervical cytology) and human papillomavirus (HPV) co-testing performed in years 2016-2020	
HCPCS CODES	
Cytology	G0123, G0124, G0141, G0143, G0145, G0147, G0148, P3000, P3001, Q0091
HPV Co-testing	G0476
CPT CODES	
HPV Co-testing	7620-87622, 87624, 87625

***Exclusion codes**: History of Hysterectomy, Acquired Absence of Cervix w/ Remaining Uterus*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Cervical cytology report/HPV report

BEST PRACTICES

1. Educate patients on cervical cancer prevention
2. Review findings and document history of a pap smear performed within the last 3 years
    a. Schedule the patient for a pap smear or refer patient to an OBGYN provider

*The listed sample codes are not inclusive and do not represent a complete list of codes

CONTROLLING HIGH BLOOD PRESSURE (CBP)

DESCRIPTION		
Patients 18–85 years of age who had a diagnosis of hypertension with their blood pressure adequately controlled (<140/90 mm Hg)		
ICD-10 CODES		
Diagnosis of Hypertension or Hypertensive Disease	10-I16	*code to the highest specificity
CPT II CODES		
Systolic BP < 130 mm Hg	074F	
Systolic BP between 130-139 mm Hg	075F	
Diastolic BP < 80 mm Hg	078F	
Diastolic BP between 80-89 mm Hg	079F	
CPT CODES		
Outpatient	9201-99205, 99211-99215, 99241-99245, 99341-99345	
HCPCS CODES		
Outpatient	G0402, G0438, G0439, G0463, T1015	

***Exclusion codes**: Acute Inpatient, Advanced Illness, ESRD, ESRD Obsolete, Frailty, Inpatient Stay, Kidney, Transplant, Non-acute Inpatient Stay, Observation, Pregnancy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Most recent systolic and diastolic blood pressure values in 2020
  - If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP

BEST PRACTICES

1. Schedule patients for an annual office visit
2. Always re-check blood pressure if initial reading is 140/90 mm Hg or greater
3. Submit timely encounters with proper ICD-10, CPT/CPT II, and out-patient visit

*The listed sample codes are not inclusive and do not represent a complete list of codes

codes

a. ICD-10 code for hypertension should be submitted to the highest specificity

*The listed sample codes are not inclusive and do not represent a complete list of codes

COMPREHENSIVE DIABETES CARE (CDC) – HbA1c Control <8

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) whose had HbA1c testing within the measurement year and most recent HbA1c test has a value < 8.0%	
ICD-10 CODES	
Diagnosis of Diabetes	*code to the highest specificity
CPT II CODES	
HbA1c < 7.0%	044F
HbA1c 7.0 – 7.9%	051F
HbA1c 8.0 – 9.0%	052F
HbA1c > 9.0%	046F

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of most recent HbA1c test
- Lab Report
  - Documentation of results/findings

BEST PRACTICES

1. Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
   a. Add HbA1c & urine microalbumin testing as a standard order for patients diagnosed with diabetes
   b. Refer the patient to an endocrinologist for further diabetic management
2. Submit timely encounters with proper ICD-10, CPT, and outpatient visit codes
   a. ICD-10 code for diabetes must be submitted to the highest specificity

*The listed sample codes are not inclusive and do not represent a complete list of codes

COMPREHENSIVE DIABETES CARE (CDC) – Eye Exam

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) who had screening or monitoring for diabetic retinal disease within the measurement year.	
ICD-10 CODES	
Diagnosis of Diabetes	code to the highest specificity
CPT II CODES	
Retinal Eye Exam Reviewed (Positive)	022F, 2024F, 2026F
Retinal Eye Exam Reviewed (Negative)	023F, 3072F

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Retinal or dilated eye exam report from an optometrist or ophthalmologist
  - Presence or absence of retinopathy must be documented

BEST PRACTICES

1. Refer patient to an optometrist or ophthalmologist for diabetic retinal exam
2. Review eye exam results with patient and document results in patient's medical record

*The listed sample codes are not inclusive and do not represent a complete list of codes

COMPREHENSIVE DIABETES CARE (CDC) – Nephropathy

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) who had nephropathy screening or monitoring test or evidence of nephropathy within the measurement year.	
ICD-10 CODES	
Diagnosis of Diabetes	code to the highest specificity
CPT II CODES	
Negative for Microalbuminuria	061F
Positive for Microalbuminuria	060F

DOCUMENTATION (SUPPLEMENTAL DATA)

Medical record must include:

- Patient name and date of birth
- Date of service of urine microalbumin test
- Documentation of results/findings

BEST PRACTICES

1. Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
    a. Add HbA1c & urine microalbumin testing as a standard order for patients diagnosed with diabetes
    b. Refer the patient to an endocrinologist for further diabetic management
2. Submit timely encounters with proper ICD-10, CPT, and outpatient visit codes
    a. ICD-10 code for diabetes must be submitted to the highest specificity

*The listed sample codes are not inclusive and do not represent a complete list of codes

COLORECTAL CANCER SCREENING (COL)
MEDICARE | COMMERCIAL

DESCRIPTION
Patients 50-75 years of age who had one of the following screenings for colorectal cancer: ▪ Colonoscopy in 2011 to 2020 ▪ Sigmoidoscopy in 2016 to 2020 ▪ Fecal occult blood test (FOBT, gFOBT, iFOBT) in 2019 to 2020 ▪ FIT DNA test in 2018 to 2020

CPT & HCPCS CODES	
FOBT	82270, 82274, G3028
Flexible Sigmoidoscopy	45330-45335, 45337-45342, 45345-45347, 45349, 45350, G0104
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121
CT Colonography	74261-74263, G0213-G0215, G0231
FIT-DNA	81528, G0464

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Lab/Pathology reports
    - Documentation of results/findings

BEST PRACTICES

1. Educate patients on the importance of colorectal cancer screening
    a. A colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer
2. Refer patient to a gastroenterologist for a colonoscopy
3. Alternatively, have patient complete an immunochemical fecal occult blood test (iFOBT)
    a. Have iFOBT kits readily available in the office to provide to patients during their visit

*The listed sample codes are not inclusive and do not represent a complete list of codes

TRANSITIONS OF CARE (TRC)

&

MEDICATION RECONCILIATION POST-DISCHARGE (MRP)

MEDICARE

DESCRIPTION	
The percentage of discharges from 1/1/2020-12/31/2020 for patients 18 years old and older who had an inpatient admission and discharge with documentation of the following four components: • Notification of Inpatient Admission • Receipt of Discharge Information • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge	
CPT CODES	
Transitional care management services (within 14 days of discharge)	9495
Transitional care management services (within 7 days of discharge)	9496
CPT II CODES	
Discharge medications reconciled with the current medication list in the outpatient medical record	111F

DOCUMENTATION

Medical record must include:

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Documentation of receipt of discharge information on the day of discharge or the following day
- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

*The listed sample codes are not inclusive and do not represent a complete list of codes

BEST PRACTICES

1. Submit timely encounters with proper coding
2. Ensure all components are documented in the medical record

*The listed sample codes are not inclusive and do not represent a complete list of codes

MEDICATION ADHERENCE – BLOOD PRESSURE, CHOLESTEROL, or DIABETES MEDICATIONS

MEDICARE

DESCRIPTION
Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for blood pressure, cholesterol, and/or diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **"Blood pressure medication"** means an ACE (angiotensin-converting enzyme) inhibitor or and ARB (angiotensin receptor blocker) drug, or a direct renin inhibitor drug. **"Cholesterol medication"** means a statin drug. **"Diabetes medication"** means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DDP-IV inhibitor, an incretin mimetic or a meglitinide drug. Members who take insulin are not included.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

*The listed sample codes are not inclusive and do not represent a complete list of codes

STATIN USE IN PERSONS WITH DIABETES (SUPD)

DESCRIPTION
Percentage of Medicare Part D beneficiaries 40-75 years who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period and remained on a statin medication of *any intensity* for at least 80% of the treatment period. **"Diabetes medication"** means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DDP-IV inhibitor, an incretin mimetic or a meglitinide drug. Members who take insulin are not included.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

*The listed sample codes are not inclusive and do not represent a complete list of codes

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

DESCRIPTION
The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one *high* or *moderate-intensity* statin medication during the measurement year. Members must have remained on a statin medication for at least 80% of the treatment period.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

*The listed sample codes are not inclusive and do not represent a complete list of codes

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15)

MEDICAID | COMMERCIAL

DESCRIPTION	
Patients 15 months of age who had one or more well-child visits with a primary care physician in 2020.	
ICD-10 CODES	
Well-Child	00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.5-Z02.6, Z02.71, Z02.82
CPT CODES	
<12 months	9381 (new) **or** 99391 (established)
12-15 months	9382 (new) **or** 99392 (established)

DOCUMENTATION (SUPPLEMENTAL DATA)

Medical record must include:

- Patient name and date of birth
- Date of service
- Health history, physical exam, physical health development, immunization history, mental health developmental history, and health education/anticipatory guidance

BEST PRACTICES

1. Submit timely encounters with proper coding
2. Identify patients who have not completed their well-child visit and call to schedule an appointment
3. PM160: Extract data from PM160 and submit as an encounter

*The listed sample codes are not inclusive and do not represent a complete list of codes

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (W34)

MEDICAID | COMMERCIAL

DESCRIPTION	
Patients 3-6 years of age who had one or more well-child visits with a primary care physician in 2020.	
ICD-10 CODES	
Well-Child	00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.5-Z02.6, Z02.71, Z02.82
CPT CODES	
Age 1-4	9382 (new) **or** 99392 (established)
Age 5-6	9383 (new) **or** 99393 (established)

DOCUMENTATION (SUPPLEMENTAL DATA)

Medical record must include:

- Patient name and date of birth
- Date of service
- Health history, physical exam, physical health development, immunization history, mental health developmental history, and health education/anticipatory guidance

BEST PRACTICES

4. Submit timely encounters with proper coding
5. Identify patients who have not completed their well-child visit and call to schedule an appointment
6. PM160: Extract data from PM160 and submit as an encounter

*The listed sample codes are not inclusive and do not represent a complete list of codes

Revised:July 2022

IMPERIAL HEALTH PLAN OF CALIFORNIA

PO Box 60874

Pasadena, CA 91116

KEY CONTACT LIST

Main Number	(626) 838- 5100
Main Fax	() (626) 380-9142
Eligibility	(800) 708-7903

Utilization Management	(800) 708-8273
Utilization Management	(626) 283-5021

Claims Department	(800) 778-9302
Claims Forwarding Address	PO Box 60874 *Pasadena, CA 91116*
Claims Payer ID (Electronic Submission)	Office Ally: IHP01

Contracting/Provider Services	(800) 830-3901
Contracting/ Provider Service Fax	(214) 452-1190

IMPERIAL HEALTH PLAN OF CALIFORNIA

To check status of referral call:
(626) 838-5100 Option 1

Pre-Certification Referral Form

Please complete all sections and fax with all clinical records to support medical necessity to:

Standard fax: (626)283-5021 or (888)910-4412
Urgent fax: (866)811-0455

CMS Defines an expedited request as 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.

A. MEMBER INFORMATION:

Member Name: (Last, First, Middle)	Member ID Number #		Date of Birth
Primary Care Physician (PCP)	Provider / NPI ID #	Phone Number	Fax Number
Referring Physician	Provider / NPI ID #	Phone Number	Fax Number

B. ICD-10-CM DIAGNOSIS CODE:

	CODE	DESCRIPTION
Primary		
Secondary		
Other		
Other		

C. CPT/HCPCS CODE:

	CODE	DESCRIPTION	QTY	UNITS
1)				
2)				
3)				
4)				

D. REFERRED TO PHYSICIAN / ANCILLARY / FACILITY:

REFERRAL PRIORITY: ☐ STANDARD ☐ URGENT

Urgent referrals are only to be submitted if the normal time frame for authorization will 1) be detrimental to the patient's life or health, jeopardize patient's ability to regain maximum function, or 3) result in loss of life, limb, or other major bodily function. All referrals not meeting urgent criteria will be downgraded to a routine referral request and follow routine turn-around times.

Referred to Physician	Provider / NPI ID #	Phone Number	Fax Number
Referred to Physician Address		Name and Direct Contact # completing this form	
Referred to Ancillary/Facility	Facility / NPI ID #	Phone Number	Fax Number
Referred to Facility Address			

E. SERVICE INFORMATION:

☐ Office ☐ Ambulatory Surgical Center ☐ Outpatient Hospital
☐ Home ☐ DME ☐ Inpatient/Acute ☐ Rehab/LTAC ☐ SNF

Requested Date of Service
Scheduled Admit Date

Payment for referred services is subject to plan benefits and member eligibility at time of service.
Do not combine multiple requests for different specialties in a single fax.

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

To check status of referral call:
(626) 838-5100 Option 1

Pre-Certification Referral Form

Please complete all sections and fax with all clinical records to support medical necessity to:

Standard fax: (626)283-5021 or (888)910-4412
Urgent fax: (866)811-0455

CMS Defines an expedited request as 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.

A. MEMBER INFORMATION:

Member Name: (Last, First, Middle)	Member ID Number #		Date of Birth
Primary Care Physician (PCP)	Provider / NPI ID #	Phone Number	Fax Number
Referring Physician	Provider / NPI ID #	Phone Number	Fax Number

B. ICD-10-CM DIAGNOSIS CODE:

	CODE	DESCRIPTION
Primary		
Secondary		
Other		
Other		

C. CPT/HCPCS CODE:

	CODE	DESCRIPTION	QTY	UNITS
1)				
2)				
3)				
4)				

D. REFERRED TO PHYSICIAN / ANCILLARY / FACILITY:

REFERRAL PRIORITY: ☐ STANDARD ☐ URGENT

Urgent referrals are only to be submitted if the normal time frame for authorization will 1) be detrimental to the patient's life or health, jeopardize patient's ability to regain maximum function, or 3) result in loss of life, limb, or other major bodily function. All referrals not meeting urgent criteria will be downgraded to a routine referral request and follow routine turn-around times.

Referred to Physician	Provider / NPI ID #	Phone Number	Fax Number
Referred to Physician Address		Name and Direct Contact # completing this form	
Referred to Ancillary/Facility	Facility / NPI ID #	Phone Number	Fax Number
Referred to Facility Address			

E. SERVICE INFORMATION:

☐ Office ☐ Ambulatory Surgical Center ☐ Outpatient Hospital
☐ Home ☐ DME ☐ Inpatient/Acute ☐ Rehab/LTAC ☐ SNF

Requested Date of Service
Scheduled Admit Date

Payment for referred services is subject to plan benefits and member eligibility at time of service.
Do not combine multiple requests for different specialties in a single fax.