# Imperial Insurance Companies, Inc.

# and

# Imperial Health Plan of the Southwest, Inc.

## Exchange/Health Insurance Marketplace

# Provider Manual 2025

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

# **Provider Manual 2025**

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## SECTION 1. INTRODUCTION

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

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

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

### 1.2 Quality Management Committee

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

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

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

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

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

## 1.3 Provider Network Management

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

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

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

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

• Phone: (800) 595-0619

• Email: pnm@imperialhealthholdings.com

## 1.4 Credentialing

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

## 1.5 Enrollment and Eligibility

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

## 1.6 Claims and Encounter Data Processing

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

# SECTION 2. IMPORTANT CONTACT NUMBERS

## 2.1 Imperial Contact Numbers

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

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

| | |
|---|---|
| Contracting/Provider Services | (800) 595-0619 |
| Contracting/Provider Service Fax | (214) 452-1190 |

## SECTION 3. RESPONSIBILITIES OF IMPERIAL'S CONTRACTED PROVIDERS

### 3.1 Medical Services Covered under Primary Care

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

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

## 3.2 Role of Specialty Care Physicians

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

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

NOTE:

Specialists can only submit referral authorization requests, through the PCP, for additional continued care or treatment of members and cannot refer members to other specialists. Unauthorized services will not be reimbursed. Specialists must notify Imperial to arrange for a Memorandum of Understanding to be in place when a non-participating provider is scheduled to take calls for the specialist or assist the specialist with a service or procedure. The use of a call answering machine <u>is not</u> 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.<br>• 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.<br>• For routine primary care services, the maximum timeline for appointments is as follows:<br>1. Physical exams and routine preventive services: 4 work weeks.<br>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.<br>• 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.<br>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.<br>• Sensitive services will be provided under the following conditions:<br>1. For minors 12 years of age and older: without necessity of preauthorization, referral, or parental consent.<br>2. For all members: confidentially, in a manner that respects the member's privacy and dignity. |

## 3.4 Telephone Access

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

## 3.5 Services for Members with Disabilities

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

TDD/TTY Access for the Hearing Impaired is 711.

## 3.6 Interpreter Services

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

## 3.7 Credentialing and Facility Site Review

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

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

The following documents are required for the initial credentialing process:

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

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

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

### A. Provider Status Change

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

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

### B. Required Reporting

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

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

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

### C. Providers Rights

As a provider you have the following rights:

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

## 3.8 Hospital Admissions and Admitting Staff

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

## 3.9 Medical Records

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

### A. Confidentiality

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

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

### B. Standard Requirements

The following requirements apply to ALL Medical Records:

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

### C. Notation Requirements

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

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

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

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

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

Progress notes must document the following:

- Height, weight, and vital signs;
- The patient's chief complaint;
- Unresolved problems from previous visits;
- A physical exam consistent with the chief complaint; and
- A working diagnosis;

- Tests, referrals, consults, and a plan of treatment consistent with working diagnosis;
- Prescribed medications include name of drug, dosage, and administration frequency, and duration;
- Follow up plan and date of return visit or PRN; and
- Health education and preventative care.

- Telephone advice is documented
- The physician initials and dates consultant summaries, laboratory, and other diagnostic reports. Consultant summaries and abnormal lab and diagnostic test results have a chart entry including a follow up care plan
- Immunization records appropriate to age are initiated on all patients
- Preventive screening and health education services are offered
- Problems lists are updated with each visit and unresolved problems are addressed at the next visit.
- Missed appointments are to be documented in the medical record. At a minimum, three attempts will be made to determine the cause of the missed appointment.
- Documentation includes a notation of the time and method used to contact the member
- Refusal to have a translator outside of family and or friend must be documented
- Any access to care problems is to be documented in the medical record

### 3.10 Vaccine and Immunization Administration

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

## SECTION 4. DATA AND CLAIMS SUBMISSION

### 4.1 Claims Submission

Industry standards require that all claims be submitted within 60 calendar days, or as defined in your provider services agreement following the end of the month. Claims will be processed, and payments made in accordance with the Timeliness Guidelines promulgated pursuant to the CMS and State regulations. Claims should be submitted to Imperial for services performed by the physician according to the contract.
Imperial will only accept claims submitted on an industry standard CMS 1500 or UB04 Claim Form.

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

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

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

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

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

**Imperial Insurance Companies, Inc.:**

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

**Imperial Health Plan of the Southwest, Inc.:**

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

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

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

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Please refer to the Compensation Fee Schedule within your Provider Agreement to determine the payment amount you will receive for services rendered. All payable claims shall be processed in accordance with the applicable fee schedules and guidelines promulgated by each State.
Special services that cannot be identified with the appropriate CPT or HCPCS codes shall undergo Imperial's medical review and, if allowable, will be processed in accordance with the reimbursement rates generally provided in the community where care was provided.

## SECTION 5. ENROLLMENT AND ELIGIBILITY

### 5.1 Eligibility Verification

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

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

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

**Claims Processing:**

**First Month of Grace Period:** Clean claims received for services rendered during the first month of a grace period will be processed using Imperial Insurance Companies, Inc.'s standard processes and in accordance with state and federal regulations and within established turn-around-times.
**Second/Third Month of Grace Period:** Clean claims received for services rendered during the second and third months of an APTC Member's grace period will be pended until the member premium is paid in full. If the APTC Member is terminated for non-payment of the ***full premium*** at the end of the grace period, Imperial ***will deny claims for services rendered in the second and third months of the grace period. If a member is termed for non-payment of premium, they will be responsible for the cost of health services they receive after their last day of coverage.***

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

### 5.2 Eligibility List

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

[1] An APTC Member is a member who receives Advanced Premium Tax Credits (premium subsidy), which helps to offset the cost of monthly premiums for the member.
[2] A Non-APTC Member is a member who is not receiving any Advanced Premium Tax Credits (APTC) and is therefore solely responsible for the payment of the full monthly premium amount.

### 5.3 Member Disenrollment

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

### 5.4 Provider Status Change

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

## SECTION 6. REFERRALS

### 6.1 Referral Authorization Process and Guideline

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

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

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

In accordance with NCQA standards, Imperial's UM staff and medical directors who make or supervise utilization related decisions base medical coverage decisions only on the clinical appropriateness of care and service. Imperial does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. In addition, there are no financial incentives for Utilization Management decision makers, and Imperial does not encourage decisions that result in underutilization.

### 6.2 Referral Submission Process for Routine and Urgent Referrals

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

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

The following information must be provided to avoid unnecessary delays:

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

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

6.3 Guidelines on Authorization Turn-Around Time

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

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

## 6.4 Approved Referrals

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

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

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

## 6.5 Denied Referrals

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

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

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

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

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

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

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

## 6.6 Emergency Room Utilization, Urgent Care and Emergent Referrals

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

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

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

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

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

Procedure for Emergent Referrals:

1. Make sure the General Referral Form contains the following information: member's name, reason for referral, member ID number, number of visits requested, specialist's name, CPT and ICD-10 codes.

2. Fax a copy of the General Referral Form to Imperial's UM department at (866)-811-0455. Requests may also be phoned in.

3. The UM department will review eligibility, benefit coverage, and medical necessity.

4. The PCP and Specialist will receive a copy of the authorization, either by fax or electronically, within 72 hours if the authorization is approved, and within 48 hours if the authorization is denied or modified. Verbal authorizations may be given but need to be followed up in writing.

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

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

## SECTION 7. CASE MANAGEMENT PROGRAM

### 7.1 Case Management Referrals/Eligibility Criteria for Case Management Referrals

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

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

### 7.2 Case Identification and Enrollment Criteria

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

of care and outcomes while reducing avoidable costs.

General program inclusion criteria include:

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

## SECTION 8 NON -COVERED PROGRAM SERVICES

### 8.1 Non-Covered Services

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

## SECTION 9. LINKED AND CARVED OUT SERVICES

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

- Pediatric Dental
- Pediatric Vision
- Pharmacy

## SECTION 10. COMPLAINTS AND GRIEVANCES

### 10.1 Member Complaints and Grievances

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

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

Common reasons for grievances include:

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

### 10.2 Claims Settlement & Grievance Practices

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

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

### 10.3 Member and Provider Satisfaction Surveys

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

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

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

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

Form 14.3 is Provider Satisfaction Form. This form is for the PCP to complete. Both

forms should be returned to Imperial by fax at the identified number at the bottom of

the forms.

## SECTION 11. COMPLIANCE

### 11.1 Code of Conduct and Business Ethics

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

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

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

## 11.2 Compliance Program

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

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

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

## 11.3 Fraud, Waste and Abuse Compliance

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

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

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

## 11.4 Privacy Practice Notice Guidelines

### A. Background

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

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

## B. Federal Requirements

Standards for Privacy of Individually Identifiable Health Information

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

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

In general, the content of the notice must contain:

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

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

## SECTION 12. Quality Management Program

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

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

Purpose

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

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

Scope

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

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

The QM program addresses:

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

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

Goals and Objectives

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

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

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

Strategy

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

*Work Plan*

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

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

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

*Quality Improvement Initiatives*

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

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

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

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

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

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

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

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

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

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

*Measurement Process*

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

*Communication and Feedback*

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

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

*Annual Evaluation and Update of the QM Program*

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

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

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

Monitoring Activities

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

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

Annual Delegation Oversight Audit using a designated audit tool:

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

Enforcement and Compliance

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

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

Authority and Responsibilities

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

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

*Chief Executive Officer*

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

*Senior Medical Director*

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

QMC Structure

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

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

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

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

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

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

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

QMC Subcommittees

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

*Peer Review*

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

Structure

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

Function

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

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

*Credentialing*

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

Role

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

Structure

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

Function

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

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

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

*Pharmacy and Therapeutics (P&T)*

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

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

Role

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

Structure

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

Function

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

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

*Utilization Management (UM)*

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

Role

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

Structure

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

Function

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

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

QMC Responsibilities

- Annually review, modify, and approve:
  - 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 13. PROVIDER AND HOSPITAL ROSTER

### 13.1 Laboratory

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

### 13.2 Radiology/Diagnostic Centers

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

### 13.3 Contracted Hospital Facilities

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

### 13.4 PCP and SPECIALIST ROSTER

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

## SECTION 14. CLAIMS

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

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

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

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

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

**Imperial Insurance Companies, Inc.:**

- **Arizona Exchange Claims Department**
  P.O. Box 60567
  Pasadena, CA 91116
  • Electronic Office Ally Payor ID# IEXAZ

- **Texas Exchange Claims Department**
  P.O. Box 61300
  Pasadena, CA 91116
  • Electronic Office Ally Payor ID# IEXTX

- **Nevada Exchange Claims Department**
  P.O. Box 60590
  Pasadena, CA 91116
  • Electronic Office Ally Payor ID# IEXNV

**Imperial Health Plan of the Southwest, Inc.:**

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

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

**Tax ID and National Provider Identifier Requirements**

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

## Claim Format:

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

## Documentation

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

**Billing and balance billing members**

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

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

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

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

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

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

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

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

**Coordination of Benefits**

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

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

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

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

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

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

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

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

## SECTION 15. OFFICE ALLY & ONLINE SERVICES

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

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

Our on-line features include:

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

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

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

Please note our payer ID's:

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

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

## SECTION 16. PATIENT'S RIGHTS AND RESPONSIBILITIES

**It is the Patient's Rights to:**

**We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)**

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;

Imperial Insurance Companies, Inc. (the "plan") has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1-800-595-0619, TTY 711

| | | |
|---|---|---|
| November 1 – January 15: | Monday – Sunday | 6:00 a.m. – 8:00 p.m. PST |
| January 16 – October 31: | Monday – Friday | 6:00 a.m. – 8:00 p.m. PST |

These rights and responsibilities are for all members, regardless of race, sex, culture, economic, educational, or religious background.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services at 1-800-595-0619, TTY 711. You may also file a complaint directly with the Office for Civil Rights. Contact information is included in your Evidence of Coverage.

**We must ensure that you get timely access to your covered services and drugs**

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. Call Member Services at 1-800-595-0619 to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.
As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Prescription drugs within a reasonable amount of time, call 1-800-595-0619, TTY 711, and discuss your options. If we have denied coverage for your medical care or drugs and you do not agree with our decision, your Evidence of Coverage tells what you can do.

1. 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;

2. 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;

3. 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;

4. 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;

5. 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;

6. Be informed of any human experimentation or other research or educational projects affecting his or her care or treatment;

7. To personal privacy and confidentiality of information;

**We must protect the privacy of your personal health information**

You will always be treated with respect and dignity.

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used.

**Imperial is a “Covered Entity” under HIPAA**

A “covered entity” is defined in 45 CFR 160.103 as:

1. A health plan;
2. A health care clearinghouse; or

3. A health care provider who transmits any health information in electronic form in connection with a transaction for which the Secretary of HHS has adopted standards under HIPAA (45 CFR Part 162).

Examples of covered entities include:

- Imperial
- Hospital organizations that transmit patient information electronically for billing purposes;
- Physician practices, clinics, and groups that use electronic medical records or engage in online prescription ordering; and health insurers that maintain online policyholder portals
- Pharmacies
- Some laboratory companies also would be considered covered entities if they electronically bill for their services or engage in other electronic transactions for which HHS has adopted standards.

A "non-covered" entity is an individual, business, or agency that is NOT a health care provider that conducts certain transactions in electronic form, NOT a health care clearinghouse, and NOT Imperial.

Examples of non-covered HIPAA entities:

- Fitbit
- Olive AI
- Zus Health
- Vim*

**How do we protect the privacy of your health information?**

- We make sure that unauthorized people do not see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through the individual marketplace- health care exchange, we are required to give CMS or state regulators your health information if requested. If state regulators or CMS release your information for research or other uses, this will be done according to Federal or state statutes and regulations.

## You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services at 1-800-595-0619, TTY 711.

- **HIPAA protects your health information when it is held by Imperial.** However, it is also important to protect health information that you control. If you store health information on your personal computer or mobile device, exchange emails about it, or participate in health-related online communities, here are a few things you should know:

- While the HIPAA Privacy and Security Rules are in place to protect and secure your health information when it is held by Imperial and your doctor or hospital, those laws do not apply if you share your health information with an organization that is not covered by HIPAA. For example, if you post that information online yourself — such as on a message board about a health condition, it is not protected by HIPAA. **Never post anything online that you do not want to make public.**

- Imperial and your doctor use tools to protect and secure your health information at their offices. You can do the same at home. If you have health information stored on your home computer or mobile device — or if you discuss your health information over email — simple tools like passwords can help keep your health information secure if your computer is lost or stolen.

- There are medical identity thieves that could try to use your personal and health insurance information to get medical treatment, prescription drugs, or surgery. The best way to protect yourself against this possibility is to make sure you verify the source before sharing your personal or medical information. Safeguard your medical and health insurance information and shred any insurance forms, prescriptions, or physician statements. For more information about medical identity theft, visit the Federal Trade Commission (FTC) website to learn how to protect yourself at https://reportfraud.ftc.gov/#/.

- If you store your health information online, you should be sure to read the website's privacy policy and terms of service. For practical additional tips to help you protect and secure your health information online, visit: OnGuardOnline.gov.

**How can I file a complaint?**

If you believe your information was used or shared in a way that is not allowed under the HIPAA Rules, or if you were not able to exercise your rights, you can file a complaint with Imperial or your provider. The notice of privacy practices you receive from us will tell you how to file a complaint. You can also file a complaint with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights or your State's Attorneys General Office.

If you believe that an online company that is not covered by HIPAA, such as a message board, has shared your health information in a way that conflicts with their privacy policy on their website, you can file a complaint with the Federal Trade Commission at: OnGuardOnline.gov.

## We must give you information about the plan, its network of providers, and your covered services

As a member of the plan you have the right to get several kinds of information from us. You have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.

If you want any of the following kinds of information, please call Member Services at 1-800-595-0619, TTY 711.

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members.

- **Information about our network providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers and pharmacies in the plan's network, see the provider/pharmacy directory that was sent to you upon enrollment and available on our website at www.imperialhealthplan.com. You can also call Member Services at 1-800-595-0619, TTY 711.
- **Information about your coverage and the rules you must follow when using your coverage.**
    - Your EOC explains what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - To get the details on prescription drug coverage, please call Member Services at 1-800-595-0619, TTY 711.
- **Information about why something is not covered and what you can do about it.**
    - If a medical service or prescription drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

If you are not happy or if you disagree with a decision, we make about what medical care or prescription drug is covered you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, call Member Services at 1-800-595-0619., TTY 711.

8. Access information contained in the patient's medical record, within the limits of the law; and

9. 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;

**We must support your right to make decisions about your care.**

**You have the right to know your treatment options and participate in decisions about your health care**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision.

10. Follow the plans and instruction for care agreed upon with his/her practitioners;

11. Provide, to the extent possible, information that the medical group and its practitioners and providers need in order to care for the patient;

**You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different name for them.

Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what you can to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. The plan cannot advise you as to how to complete the form.

- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

  **Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital).

  If you have any problems or concerns about your covered services or care, your EOC gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

  You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services at 1-800-595-0619, TTY 711.

**If it is about discrimination, call the Office for Civil Rights**

- If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights. You may file a complaint to the OCR by mail at: Centralized Case Management Operations U.S. Department of Health and Human Services 200 Independence Avenue, S.W, Room 509F HHH Bldg. Washington, D.C. 20201, email: OCRComplaint@hhs.gov or via the OCR Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. A complaint must be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause".

**Is it about something else?**

If you believe you have been treated unfairly or your rights have not been respected, *and* it is *not* about discrimination, you can get help dealing with the problem you are having you can **call Member Services** at 1-800-595-0619, TTY 711.

**How to get more information about your rights**

If you need more information about your rights **call Member Services** at 1-800-595-0619, TTY 711.

**You have the right to make recommendations regarding the Rights & Responsibilities Policy**

Send your comments to:

Imperial Health Plan of California, Inc.
Attention: Member Experience
P.O Box 60874
Pasadena, Ca 91116

12. Contact his/her physician or health plan with any questions or concerns about health benefits or health care services;
13. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.

**YOU HAVE SOME RESPONSIBILITIES AS A MEMBER OF THE PLAN**

**What are your responsibilities?**

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services at 1-800-595-0619, TTY 711. We are here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the Evidence of Coverage booklet sent to you in the mail when you enrolled in the plan to learn what is covered for you and the rules you need to follow to get your covered services.

  The Evidence of Coverage is also posted on our website at www.imperialhealthplan.com.

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care and prescription drugs. Your membership ID Card was sent to you with the EOC when you enrolled in the plan.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you can about your health problems and give them the information, they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the- counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you do not understand the answer you are given, ask again.
  - Make every effort to understand your health problems and participate in developing mutually agreed-upon treatment goals

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services at the number listed in you EOC.
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** Your EOC talks about our service area. We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

For more information on how to reach us, including our mailing address, please see your EOC.

## The Right to Make Recommendations regarding our Member Rights and Responsibilities Policy

As a member, you have the right to make recommendations regarding this organization's member rights and responsibilities policy.

If you would like to make any recommendations regarding either the policies or this document, please contact Member Services at 1-800-595-0619, TTY 711.

## SECTION 17. NCQA REQUIREMENTS

### Member Experience:

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

### 1. Network Management:

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

- Providers are required to meet strict quality and accessibility standards, including minimum visitation times, geographic distribution, and cultural competence training. Our network adequacy is assessed annually through member feedback and geographic analysis to ensure all members have access to the required range of services within reasonable travel distances.

- Our network management strategy ensures access to a comprehensive range of providers that meet our criteria for quality and performance. The network is reviewed annually to ensure adequate access for all members to primary care, specialty care, and emergency services. This includes ongoing monitoring of provider availability and service utilization to adjust the network as needed to meet member needs.

### 2. Population Health Management

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

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

### 3. Utilization Management

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

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

### 4. Quality Improvement

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

outcomes.

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

## 5. Quality Improvement Program

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

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

activities.

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

### QI 6.1 Annual Work Plan

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

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

### QI 6.2 Annual Evaluation

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

- The evaluation includes a description of completed and ongoing QI activities, trending performance measures, and an assessment of the program's overall effectiveness in improving the quality and safety of clinical care.
  The evaluation is used to identify areas for improvement and to make recommendations for changes to the QI program.

### QI 6.3 Committee Responsibilities

The QI Committee is responsible for:

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

### QI 6.4 Diversity, Equality and Inclusion (DEI)

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

- The organization has a DEI plan that outlines its goals and strategies for promoting DEI in the workplace.

- The organization believes that a diverse and inclusive workforce leads to better decision-making and improved outcomes for all members.
- The QI program also engages with diverse stakeholders to get their input on quality improvement initiatives.

## 6. Quality Management Program

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

## 7. Member Rights and Responsibilities

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

## 7.1 Member's Rights and Responsibilities Statement

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

## 7.2 Distribution of Rights Statement

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

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

## 8. Subscriber Information

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

## 8.1 Distribution of Subscriber Information

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

## 9. Interpreter Services

- The organization provides interpreter services to members who do not speak English or who have limited English proficiency.
- The organization provides interpreter services in a variety of languages, including Spanish, Chinese, Vietnamese, and Korean.

- The organization provides interpreter services in a variety of formats, including in-person, telephonic, and video.
- Members can access interpreter services by contacting the organization's Member Services department.

## 10. Accuracy of Marketing Information

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

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

## 11. Assessing Member Understanding of Marketing Materials

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

## 12. Protected Health Information (PHI)

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

## 13. Member Claims Access

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

## 14. Member Claims Access by Phone

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

## 15. Pharmacy Benefit Information Online

Online availability of pharmacy benefit information, including:
https://imperialhealthplan.com

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

Prior authorization is required for all Physician Assisted Drugs (PADs) included on the Prior Authorization List. Detailed

instructions for submitting a prior authorization request are available in the Policies and Procedures section of this manual. The Prior Authorization List can be accessed on our website at https://imperialhealthplan.com. This list is regularly reviewed and updated to ensure that any changes in procedures or applicable drug recalls are communicated promptly.

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

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

## 17. Pharmacy Benefit Updates

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

## 18. Personalized Information Online

Access to online availability of personalized information, including:

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

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

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

## 19. Personalized Information by Phone

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

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

- Accessing and viewing their allowed services.

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

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

### 20. QI for Personalized Information Accuracy

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

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

### 21. Email Response Evaluation

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

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

### 22. Complaint Policies and Procedures

#### 22.1 Complaints

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

#### 22.2 Appeal Policies and Procedures

## PURPOSE:

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

## POLICY:

Imperial will ensure members have a process for resolving appeals for both coverage and non-coverage decisions made by the plan or its delegated entities in the provision of health care or prescription drug services or benefits. Imperial will fully investigate the content of the appeal and document its findings. Appeal decisions and notifications will be timely. The organization's appeal review does not give deference to the denial decision.
Imperial will maintain a dedicated log or system for processing appeals in a secure centralized location that is readily accessible to appropriate staff.
All information pertaining to appeals is housed in secure on-line folders or within the system.

**PROCEDURE:**

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

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

   - Any misclassified cases will be sent to the appropriate processing area immediately and the issuing department will be notified of error.

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

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

4. Documentation
   - Imperial will accept any information or evidence concerning the appeal from the appellant
   - The appeal will be thoroughly documented by A & G. Documentation will include:
     - Date of initial receipt
     - Who made the appeal
     - The appellant's reason for appeal when written or the recipients' transcription when verbal
     - Clinical or other information provided with the appeal request
     - Previous denial and/or appeal history
     - Follow-up activities associated with the denial and conducted before the current appeal
     - Appeal form, if provided
     - Category of the appeal

- Reason for denial, including medical necessity
- All actions taken to investigate and resolve the Appeal, including, but not limited to:

  -Denial or Notice of Action letter
  -Original claim
  - EOB
  - EOP
  - EOC
  - Follow-up activities associated with the Appeal.
- When an appellant fails to submit relevant information by the specified deadline
- All findings as a result of the investigation
- Medical Director review and rational, when appropriate
- Disposition of the appeal
- Date of resolution
- Date of any phone calls & correspondence
- IRO (Exchange) documentation including:
  - Case files submitted to the IRO
  - Decisions from IRO
  - Appellant notification of IRO decisions
  - Proof of effectuation when necessary

o Any documentation Imperial feels is relevant to the case

Exchange only:

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

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

     Exchange only:
     - For denials or reductions of coverage, Member will have continued coverage pending the outcome of the appeal until the end of the approved treatment period or the determination of the appeal
   - o Imperial may but is not required to seek reimbursement from the member for payments made.
     - Imperial may, with the Member's permission, refer the appeal directly to an IRA without conducting an internal review

   - o Imperial will allow the appellant to submit written comments, documents or other information relating to the appeal
   - o Imperial will request additional information and response from indicated parties
   - o Imperial will decide on the information provided
   - o Imperial will provide language services through bilingual staff or interpreter services to help members through the appeal process

- For appeals that were denial for medical necessity, the appeal will be reviewed by a person who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination and by a practitioner in the same or similar specialty
- The following practitioner types to be appropriate for review of the specified UM denial decisions:

  Physicians, all types:
  - Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.

  Nurse practitioners:
  - Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
  - In states where Imperial have determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.

  Doctoral-level clinical psychologists or certified addiction-medicine specialists:
  - Behavioral healthcare denials.

  Pharmacists:
  - Pharmaceutical denials.

  Dentists:
  - Dental denials.

  Chiropractors:
  - Chiropractic denials.

  Physical therapists:
  - Physical therapy denials.

  Doctoral-level board-certified behavioral analysts:
  - Applied behavioral analysis denials.
- To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:
  - Includes treating the condition.
  - Includes treating complications that may result from the service or procedure.
  - It is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.
- Imperial will authorize or provide the service or benefit as expeditiously as the enrollee's health condition requires, but no later than the timeframes listed below.
- Upon completion of the investigation a written response will be sent as noted below
- preservice appeal will be responded to within 30 days of receipt of the appeal
- expedited appeals will be responded to within 72 hours
- post service appeals will be responded to within 60 days of receipt of the appeal

6. Notification:
   - Imperial will respond to all appeals in writing. Letters will contain,
     - Directly respond to the reason for the appeal
     - Address any new information found during review
     - A response that is understandable to the member
   - Does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand
   - Explain abbreviations and acronyms in lay person language
     - Disposition of the appeal, including any duration, limitations or coverage rules, as applicable
     - Criterion, or excerpt of criterion, upon which the decision was made

- A copy will be provided upon request
    - A full and complete reason for upholding the denial in terms specific to the member's condition or request
    - Identify all reviewers who participated in making the appeal decision (by title, qualification & specialty only as applicable, not name), including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision
- For each individual, the notice includes:

  For a benefit appeal:

  - The title (position or role in the organization

  For a medical necessity appeal:

  - The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist)

    - Additional appeal rights including description, procedures and time frames, if appropriate
    - ExplainsImperial'sresolution of the complaint;
    - Reference the benefit provision, guidelines, protocol or similar criteria on which the appeal decision is based
    - Specialization of any physician or other provider consulted
    - Complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal

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

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

  - Address a written appeal to the complaint appeal panel

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

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

## REGULATORY REFERENCES:

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

NCQA HP Accreditation Standards

42 CFR §422.578-590 and 423.580-590

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

### 4.1 Nonbehavioral Complaint Assessment

### 4.2 Nonbehavioral Improvement Opportunities

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

4.2.1 The process includes an annual review of complaint data and feedback from members and practitioners.
4.2.2 The organization takes action to address any identified areas for improvement.

### 4.3 Behavioral Complaint Assessment

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

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

### 4.4 Behavioral Improvement Opportunities

4.4.1 The organization has a process for identifying and acting on opportunities to improve its behavioral health care complaint process.
4.4.2 The process includes an annual review of complaint data and feedback from members and practitioners.
4.4.3 The organization takes action to address any identified areas for improvement.

## i. Utilization Management (UM) Program Structure

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

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

### 1. Medical Necessity Criteria

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

### ii. Role of the Physician in the QI Program

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

## QI Committee's Responsibility for Recommending and Revising Policies

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

### iii. Patient Safety Strategy

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

### iv. Process for Verifying Provider Credentials

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

### 1. Process for Recredentialing Providers

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

## SECTION 18. FORMS & APPENDICES

17.1 Direct Referral Form

17.2 Direct Referral Form

17.3 EZ-Net Portal Application

17.4 EZ-Net Portal Guide

17.5 Provider Satisfaction Survey Enclosed

17.6 Key Contact List

IMPERIAL INSURANCE COMPANIES

# Direct Access Referral Form

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

***Member Information***

**Full Name** _____ **Date of Birth**_____ **Gender** ☐**M** ☐**F**

**Phone Number** _____ **Health Plan** _____ **Member ID#**_____

**PCP Name**_____**PCP Phone #**_____ **PCP Fax #**_____

## *Diagnosis*

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

## *Requested Specialist/Provider*

**Name**_____ **Specialty** _____

**Address**_____**City**_____**State**_____ **Zip Code** _____

**Phone #**_____ **Fax #** _____

| QTY | OUTPATIENT VISITS | |
|---|---|---|
| 1 | 99201 - 99204 | New Patient Consults |
| | 99211 – 99214 | Established Patient Follow-Up **(Up to 3 Visits)** |
| **QTY** | **PHYSICAL THERAPY** | |
| | MCR - 9 series MCL - X codes | Physical Therapy Evaluation and 2 treatment visits |
| **QTY** | **X-RAYS** | |
| | 73560 - 73660 | Lower Leg, Ankle & Foot |
| | 73090 - 73140 | Forearm & Hand |
| | 73030 - 73085 | Shoulder & Upper Arm |
| | 73501 - 73552 | Pelvic Region & Thigh |
| | 71045 - 71048 | Thorax (Chest) |
| | 71100 - 71130 | Ribs, Sternum & Sternoclavicular Joint(s) |
| | 72020, 72040,<br>72070 - 72082 | Spine (1-3 views) |
| **QTY** | **MAMMOGRAPHY** | |
| | 77053 – 77054,<br>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 |
| | 52000 | Cystoscopy |
| **QTY** | **HOME HEALTH** | |
| | G0299-G0300 | Skilled Nurse Visit (RN or LVN) Evaluation |
| | 52000 | Cystoscopy |

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

**Referring Provider Signature**_____ **Date** _____

**Referring Provider**_____ **Phone #**_____ **Fax#** _____

**Print name**

This form does not guarantee payments by Imperial 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 PLAN
OF THE SOUTHWEST

# Direct Access Referral Form
# EXUT

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

***Member Information***

**Full Name** _____ **Date of Birth**_____ **Gender** ☐**M** ☐**F**

**Phone Number** _____ **Health Plan** _____ **Member ID#**_____

**PCP Name**_____**PCP Phone #**_____ **PCP Fax #**_____

## *Diagnosis*

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

## *Requested Specialist/Provider*

**Name**_____ **Specialty** _____

**Address**_____**City**_____**State**_____ **Zip Code** _____

**Phone #**_____ **Fax #** _____

| QTY | OUTPATIENT VISITS | |
|---|---|---|
| 1 | 99201 - 99204 | New Patient Consults |
| | 99211 – 99214 | Established Patient Follow-Up **(Up to 3 Visits)** |
| **QTY** | **PHYSICAL THERAPY** | |
| | MCR - 9 series MCL - X codes | Physical Therapy Evaluation and 2 treatment visits |
| **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,<br>72070 - 72082 | Spine (1-3 views) |
| **QTY** | **MAMMOGRAPHY** | |
| | 77053 – 77054,<br>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 |
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| | 52000 | Cystoscopy |

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

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

**Referring Provider Signature**_____ **Date** _____

**Referring Provider**_____ **Phone #**_____ **Fax#** _____

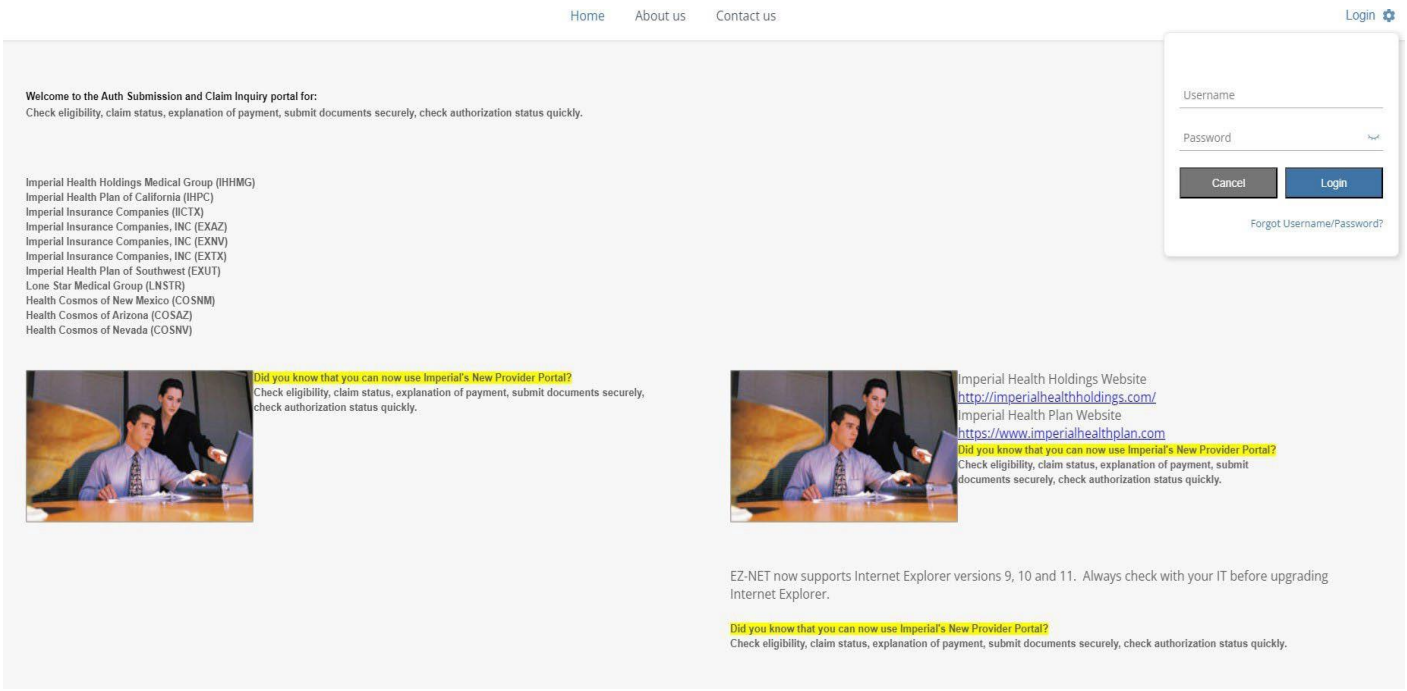
**Print name**

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

# Imperial Health EZ-Net Portal Provider Guide

# Table of Contents

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



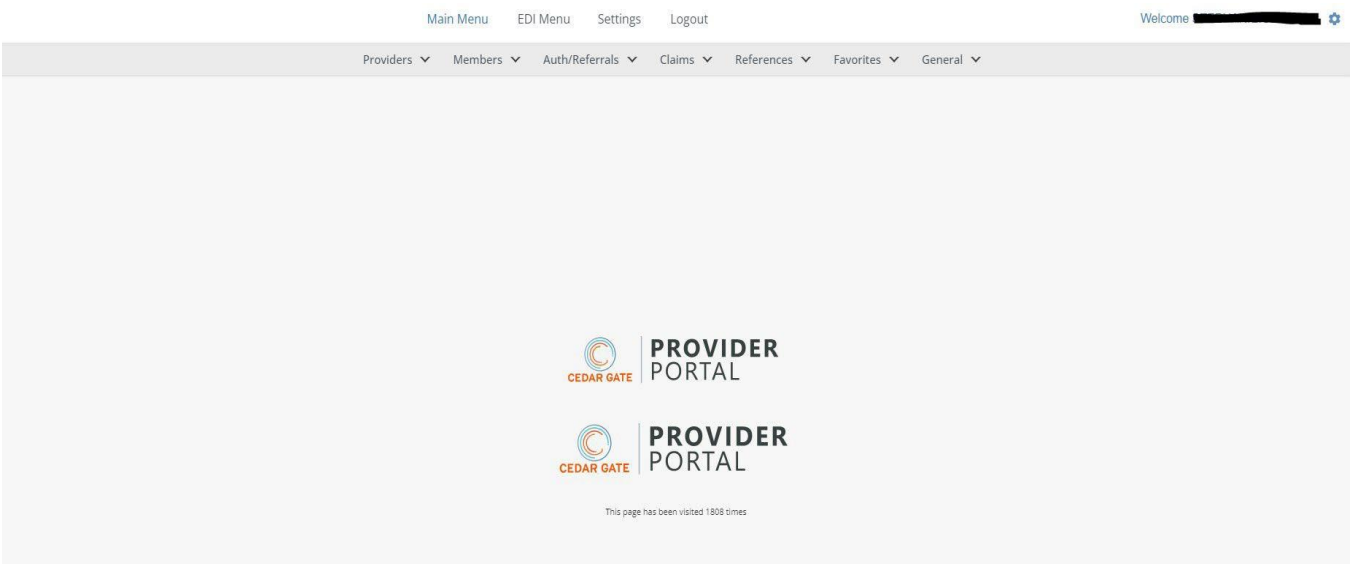

Input your username and password provided by Imperial.

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

Sign up for the EZ Net Provider Portal here: https://forms.office.com/pages/responsepage.aspx?id=5DmEMBsKOESYLX4BxkC_Z8R0IUAAoydBtDaWxFWfGoxUNThYR1pQNzNVNzMwMEY0RDNYRlJVNjZSQS4u

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

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

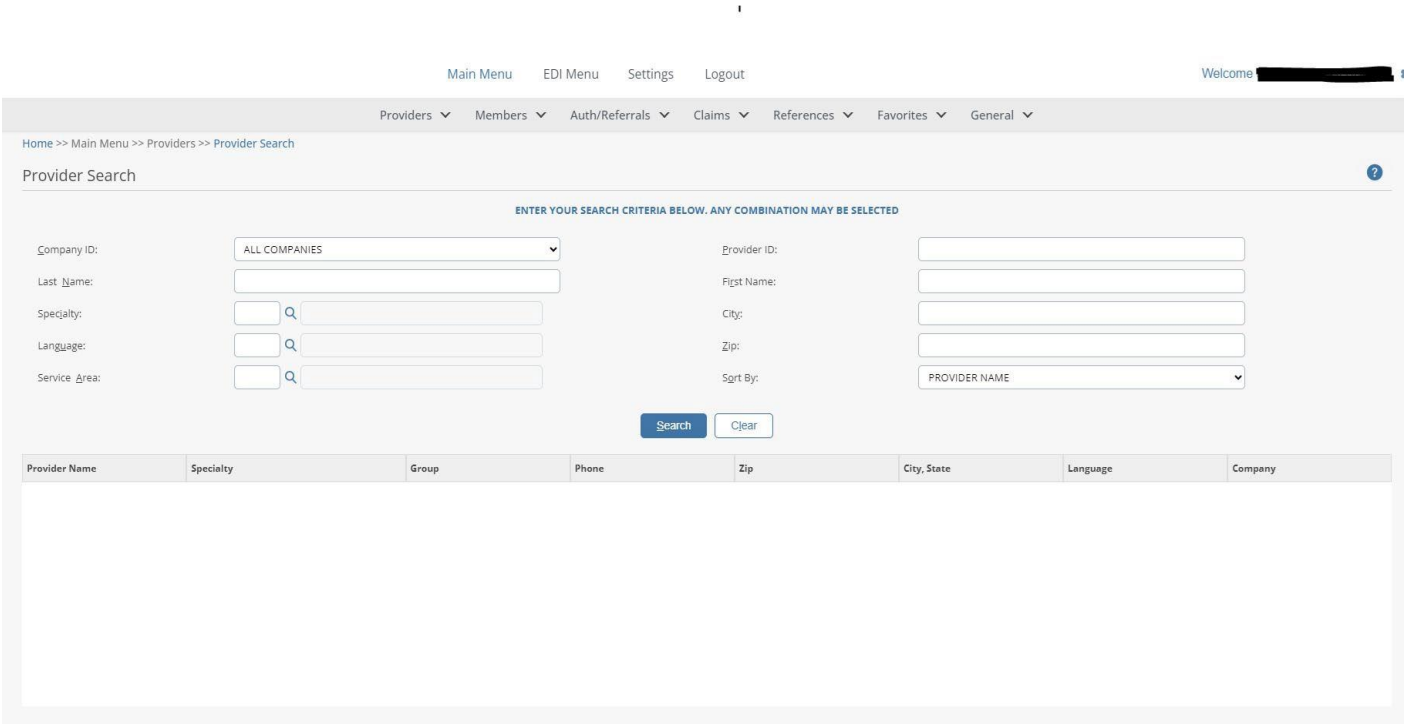


# Providers

## Search for a Provider

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

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




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

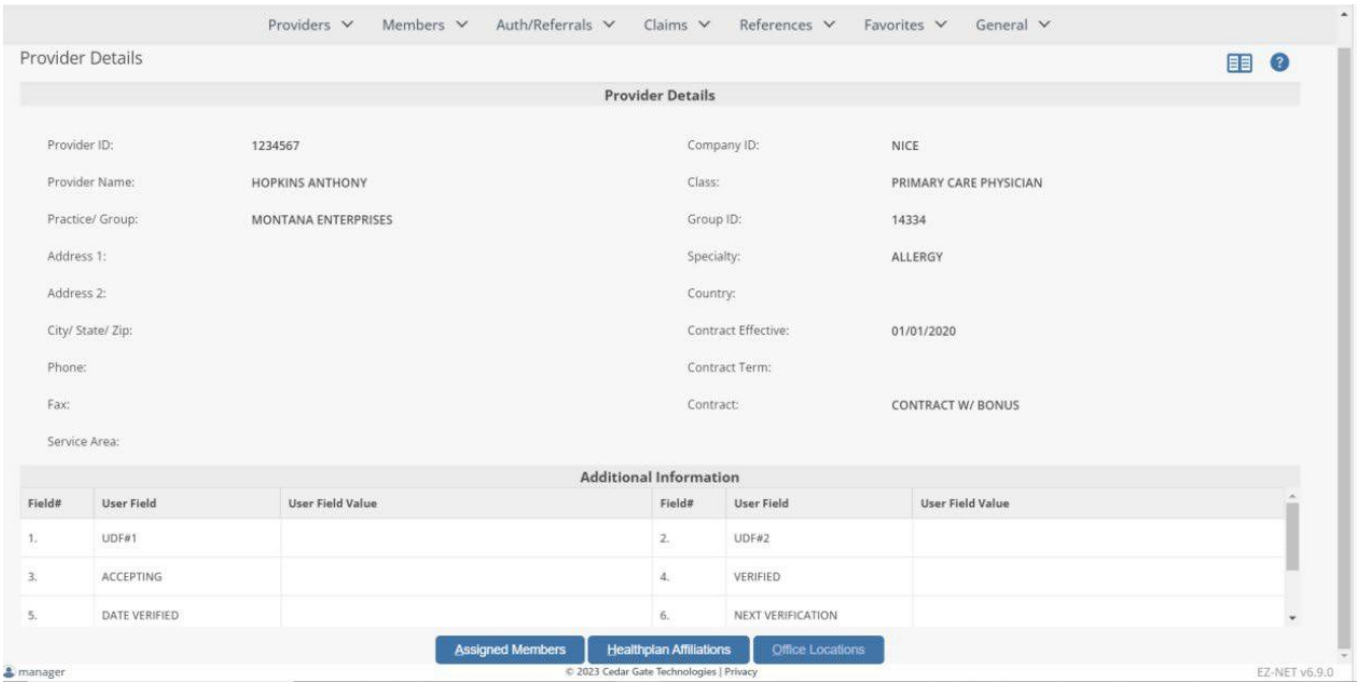
| | |
|---|---|
| First Name | First name of the Physician. Note that provider organizations (Such as "Tower Radiology") will not have "first names." |
| Specialty | Primary specialty of the physician or provider organization. Value defaults to 'None Selected,' which means that the search will not be restricted to a Provider specialty. Searches can be limited to a specific Provider specialty by using the &#65533;; button. |
| City | Name of the city in which the Provider's office is located. |
| Language | n'o can select the Language of the Physician. |
| Zip | Zip code in which the Provider's office is located. |
| Service Area | n'o select the Service area of the Physician. |
| Sort By | n'o specify the presentation order of the search results, click on the Sort By pick list and select one of the following available sort options:<br><br>Provider Name<br><br>Specialty<br><br>tity/Name<br><br>&#65533;ity/Specialty<br><br>Zip/Name |

# Provider Detail

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

| Provider Name | Specialty | Group | Phone | Zip | City, State | Language | Company |
|---|---|---|---|---|---|---|---|
| TEST123S | GYNECOLOGY | SITAM_TEST | | | | | CITRA |
| YY MM | VENDOR | VENDOR 01 FOR CAPITATION | | | | | CITRA |
| ABC GASTRO | GASTROENTEROLOGY | VALENCIA DISTRICT HOSPITAL | 8888888888 | 91724 | COVINA,CA | | NICE |
| FERNANDES DR JAMES | ABDOMINAL SURGERY | MONTANA ENTERPRISES | | | | | NICE |
| HOPKINS ANTHONY | ALLERGY | MONTANA ENTERPRISES | | | | | NICE |
| MEDLINE MEDICAL SUPPLIES | DURABLE MEDICAL EQUIPMENT | MEDLINE MEDICAL SUPPLIES | | 91101 | PASADENA,CA | | NICE |
| PCF | ALLERGY | SOMMER SPECIALTY PRACTICE | 7894758962 | 04401 | TEXAS,AK | | NICE |
| RADIOLOGY GROUP | RADIOLOGY | VALENCIA DISTRICT | 6555555555 | 564654654 | CITY,AK | | NICE |

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




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

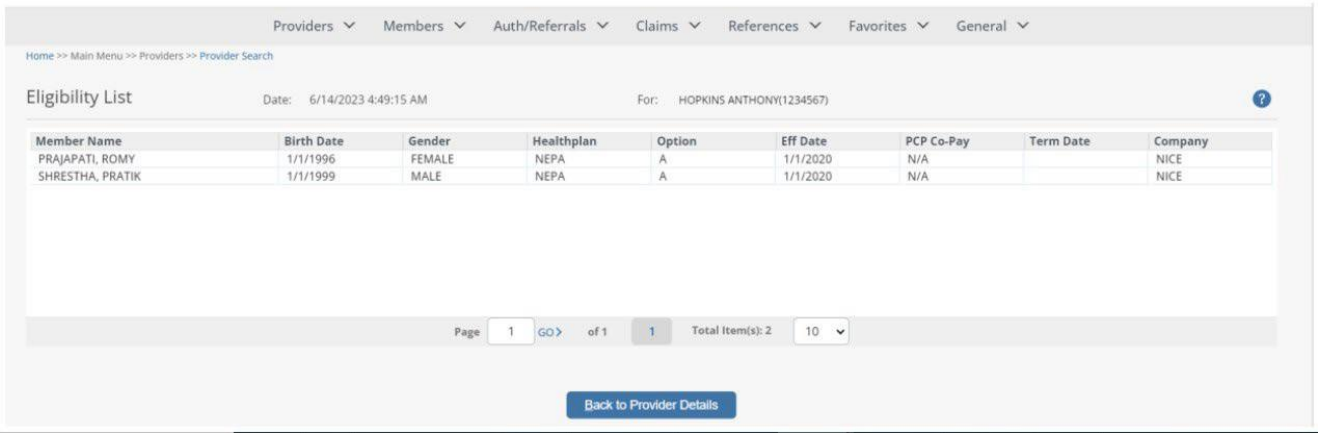
## Displaying Additional Provider Information

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

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

## Assigned Members

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

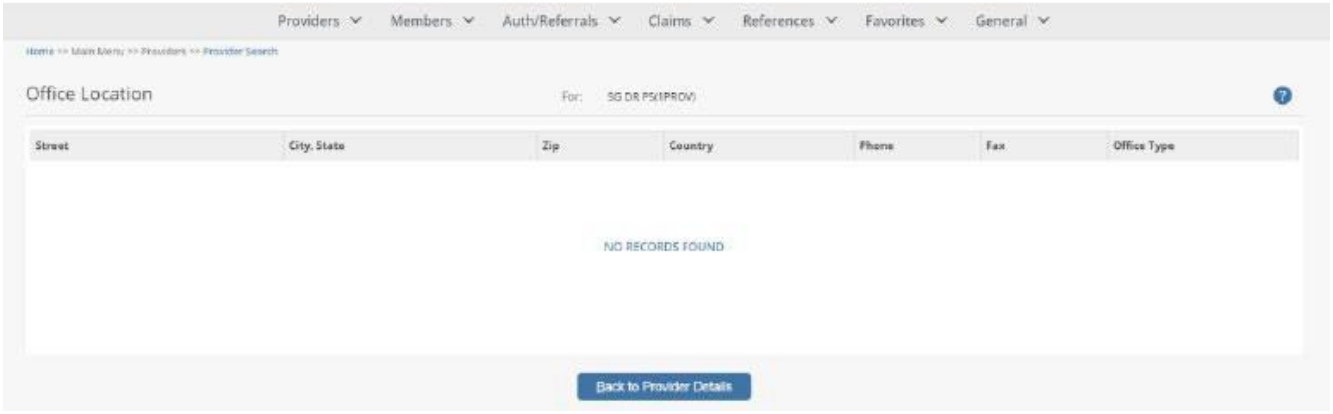


## Health Plan Affiliation

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


## Office Locations

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



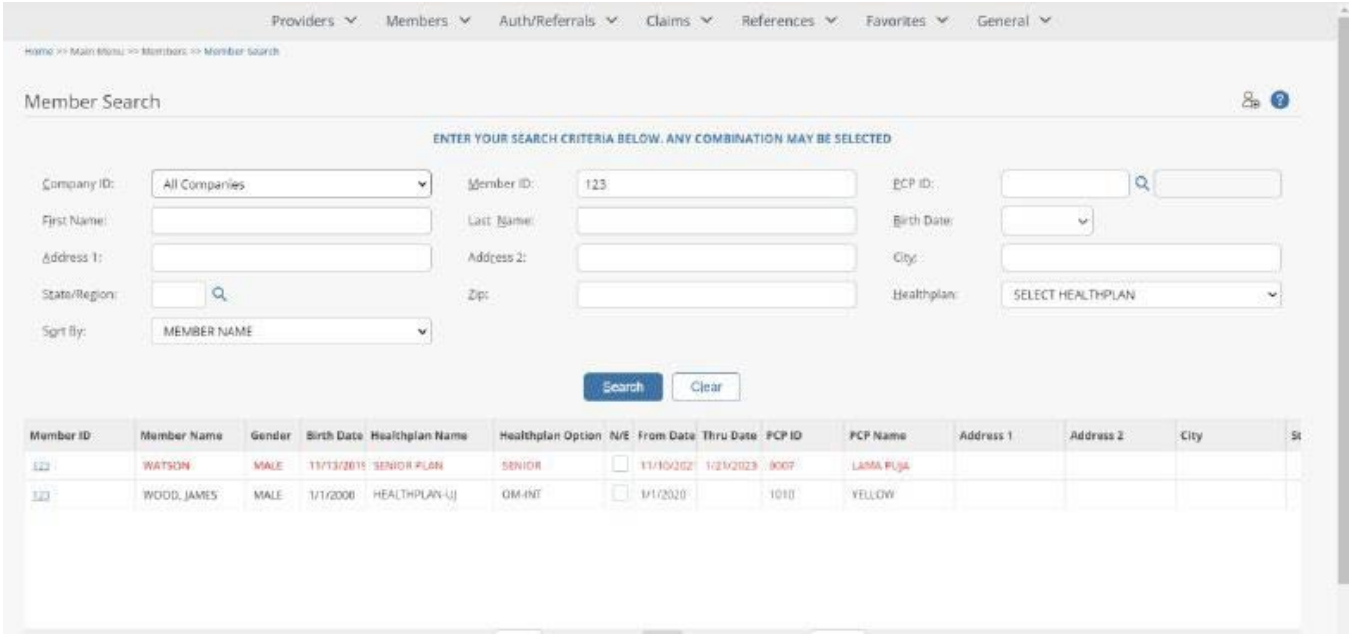
# Members

## Search for a Member

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

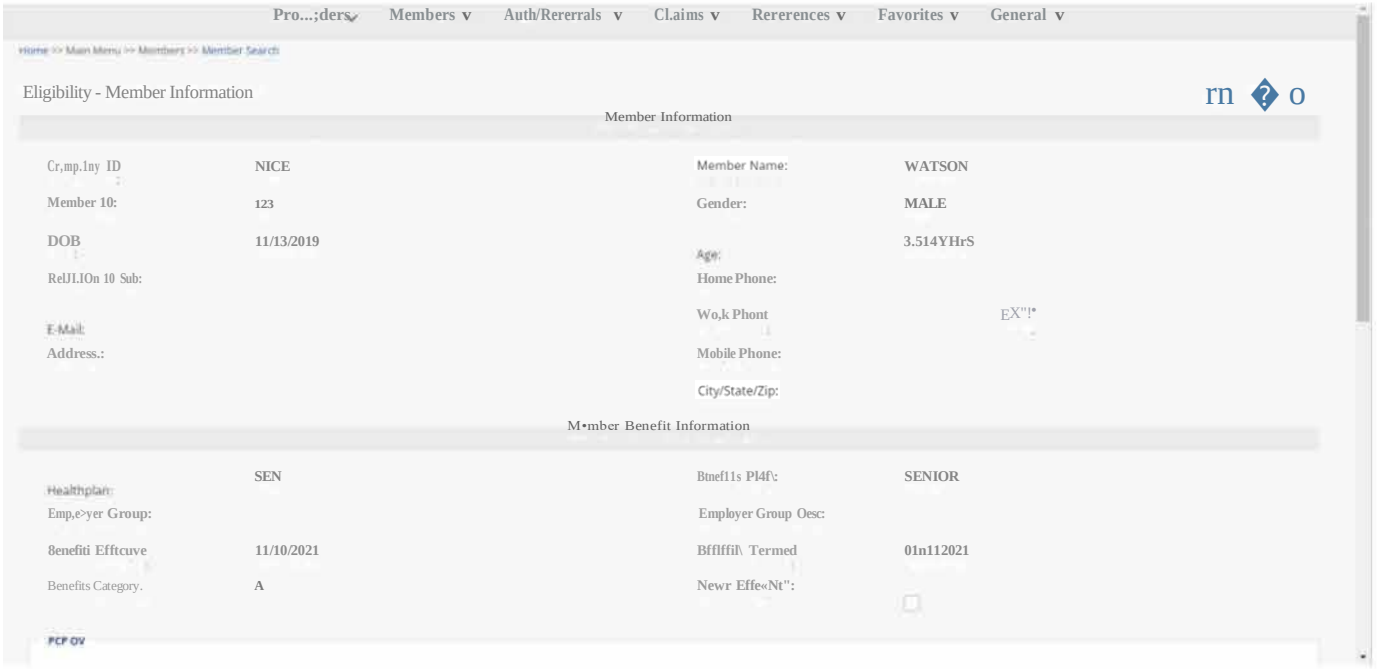
EZ-NET will display the search result in the window below, sorted in your specified order ("Sort By" drop-down list). If the system does not locate any records that meet your search criteria, a message stating that "NO RECORDS FOUND" will display. Either replace/adjust selection criteria or click on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

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



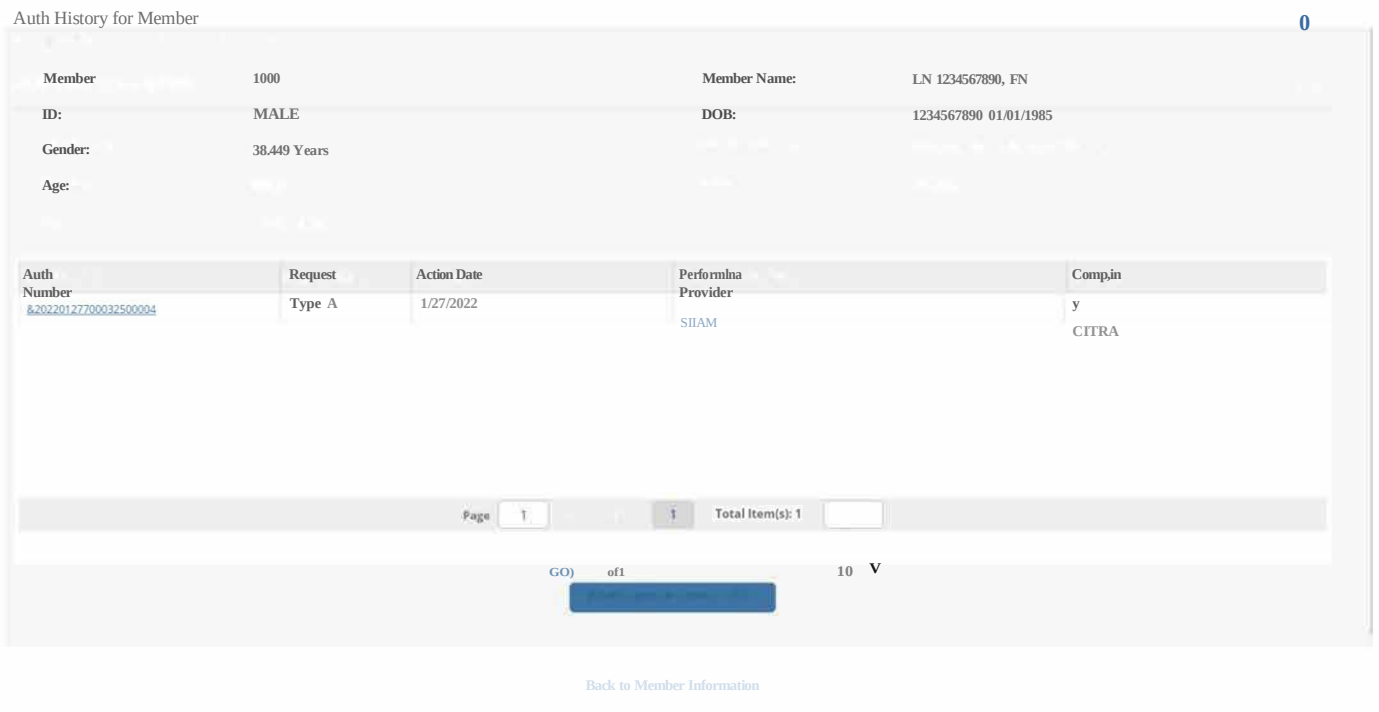

To display member details, click on a member ID in the **"Member ID"** column (in BLUE text) within the Member Search Results window. The Notes and Memos are displayed based on the PROVIDER ADMINISTRATION PORTAL Company Configurations.

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




## Viewing a Member's Authorization HistctY

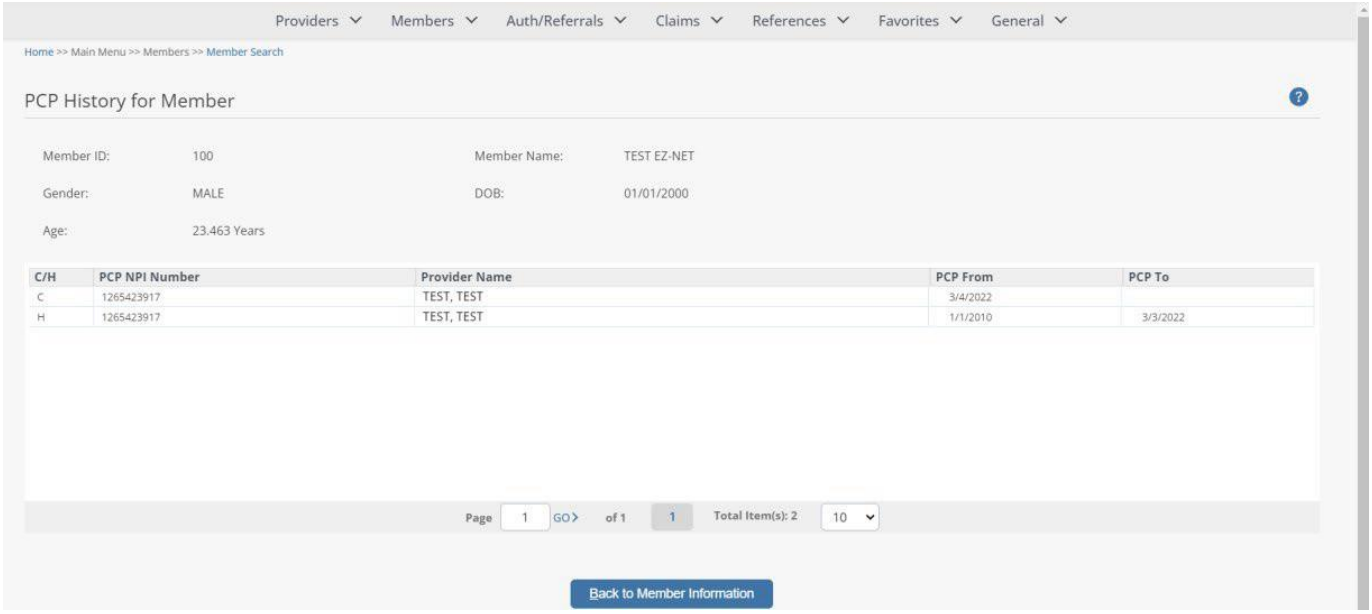
From the Member Information window, view the member's auth history by clicking on the 8uth History button to display the Authorization History for Member window.



# PCP HISTORY

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

This screen displays the PCP information for a member.

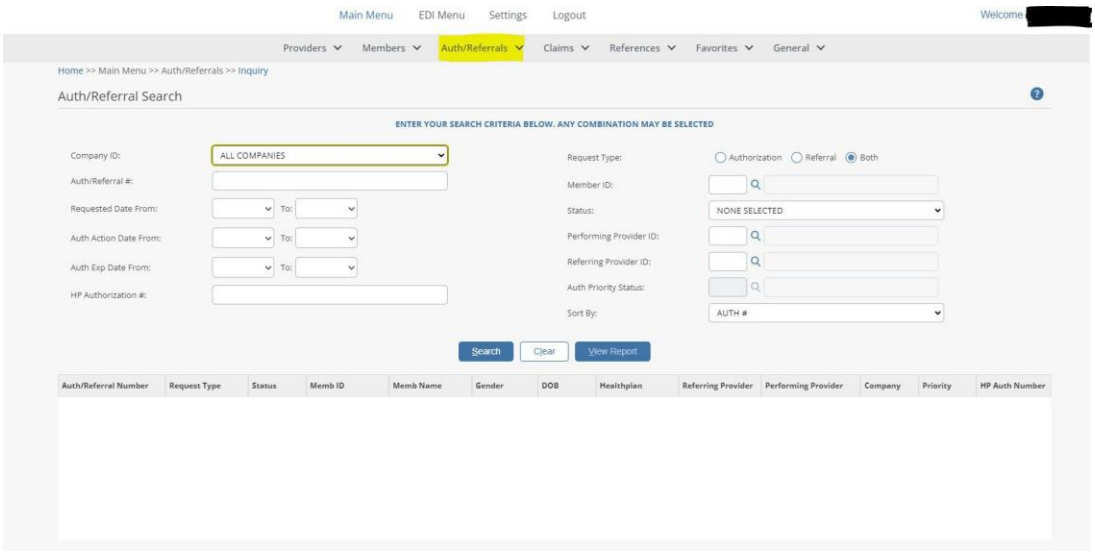


# Authorizations & Referrals

## Inquiry

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

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




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

Wednesday, June 14, 2023

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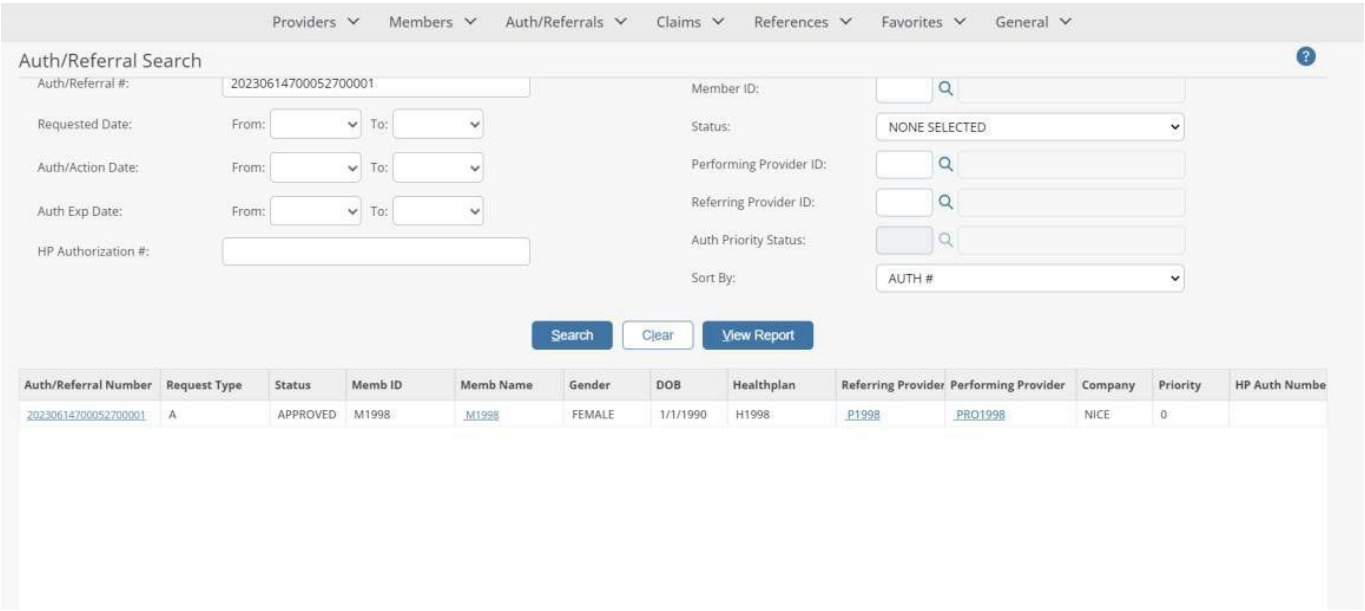
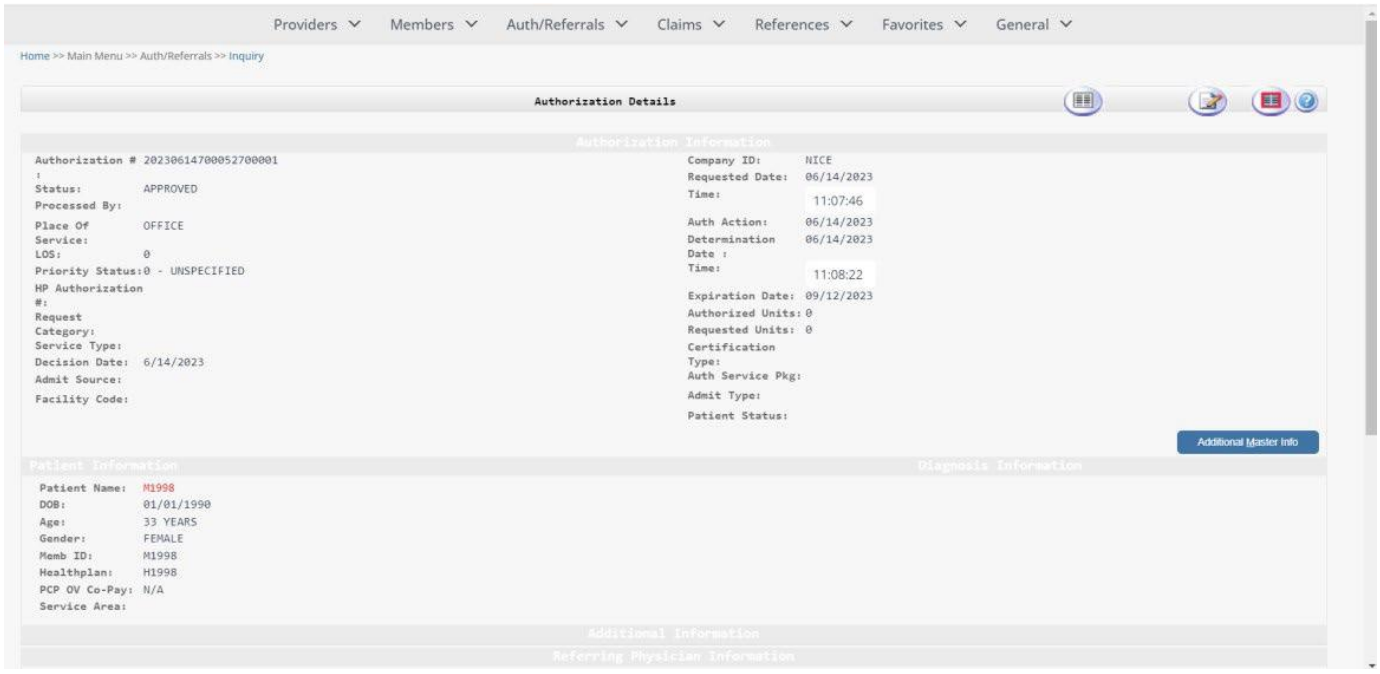
**Auth / Referral Report**

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

# AUTHORIZATION DETAILS

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

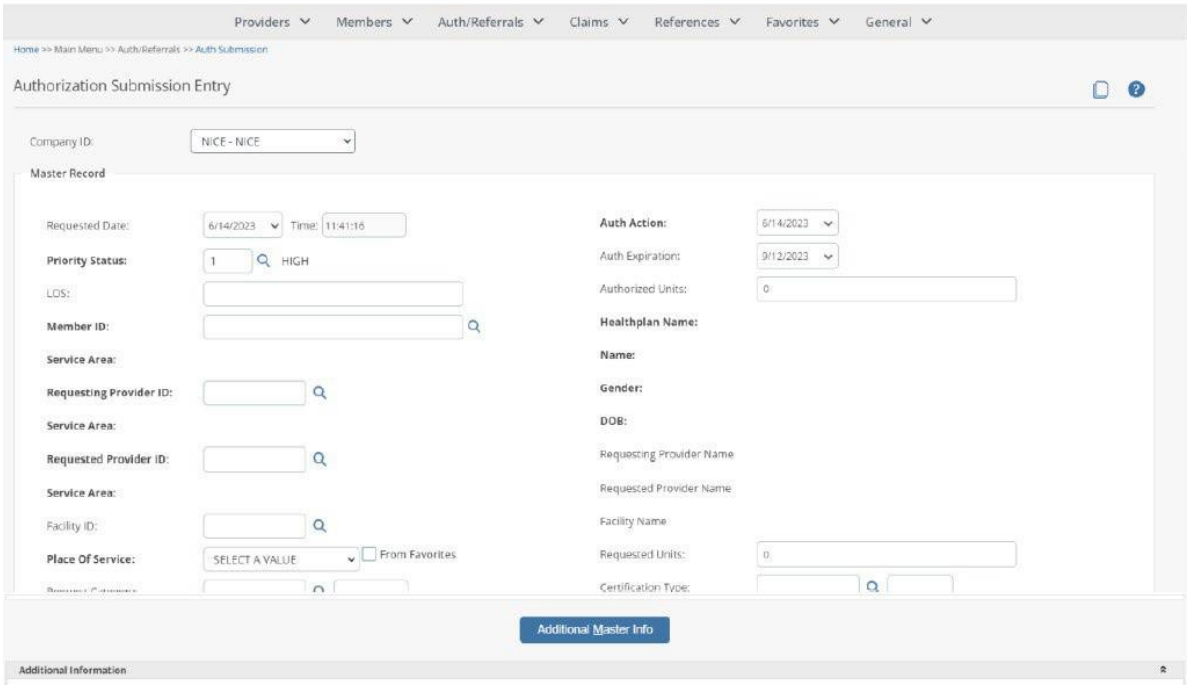


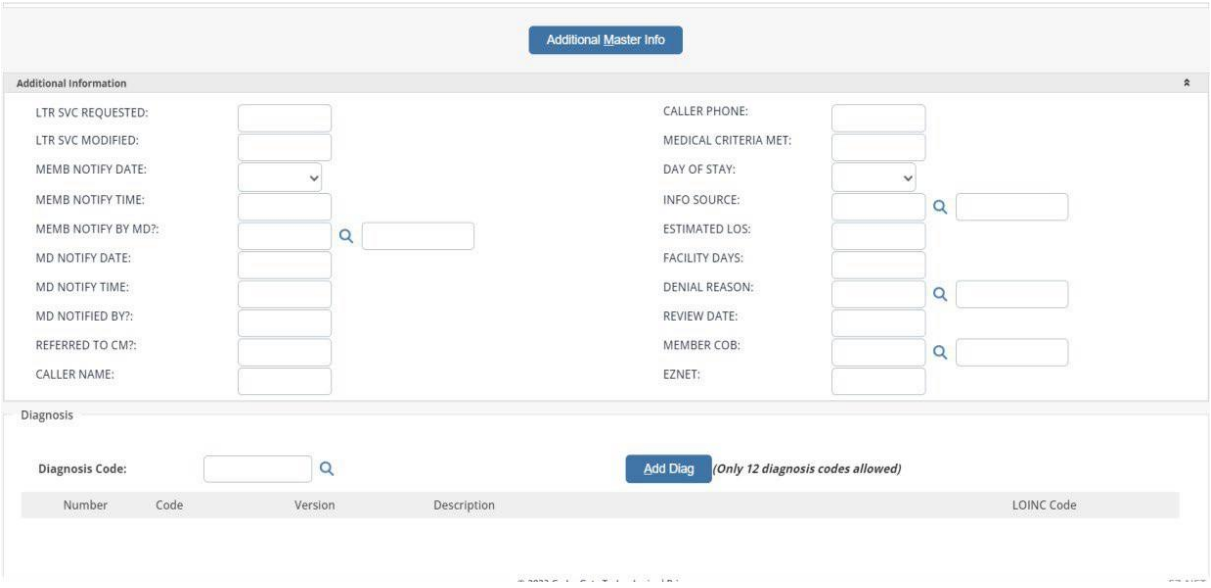



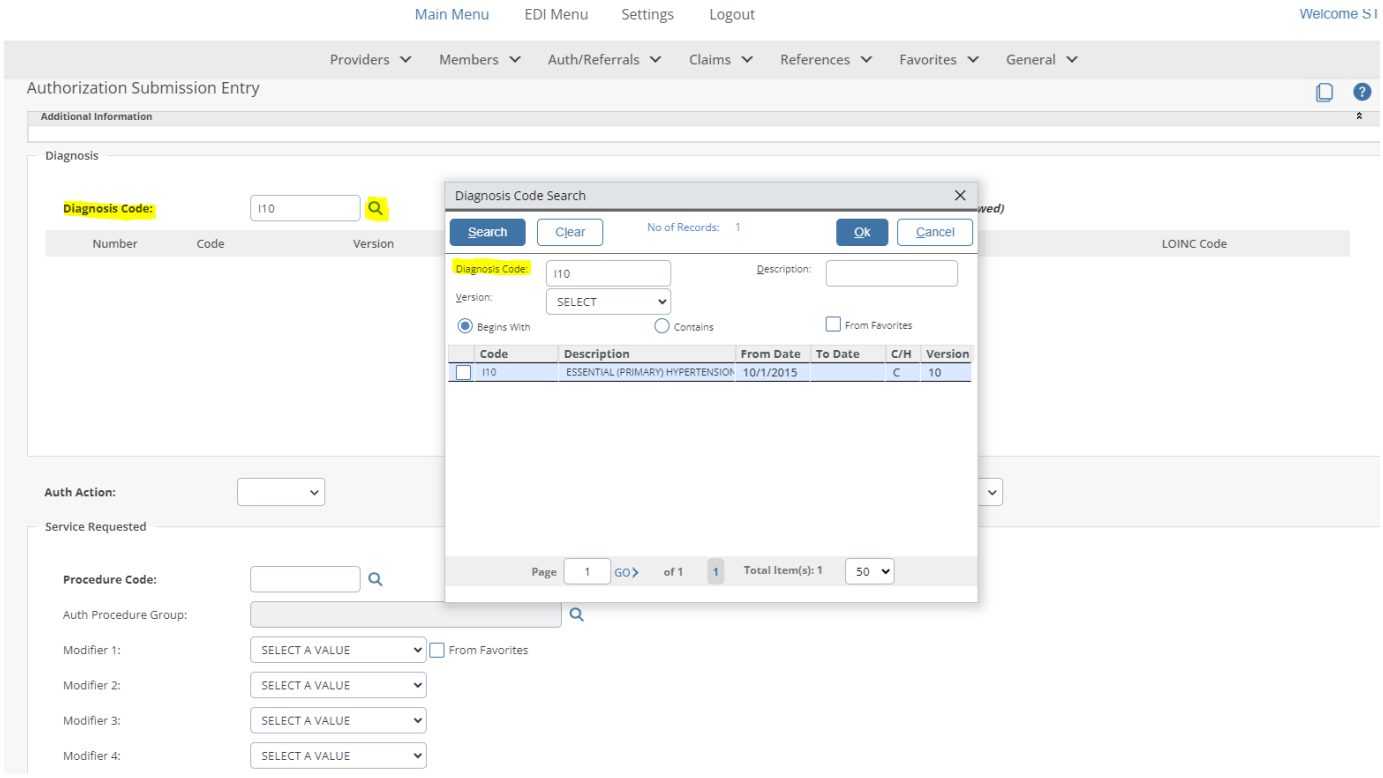
# To Request an Authorization

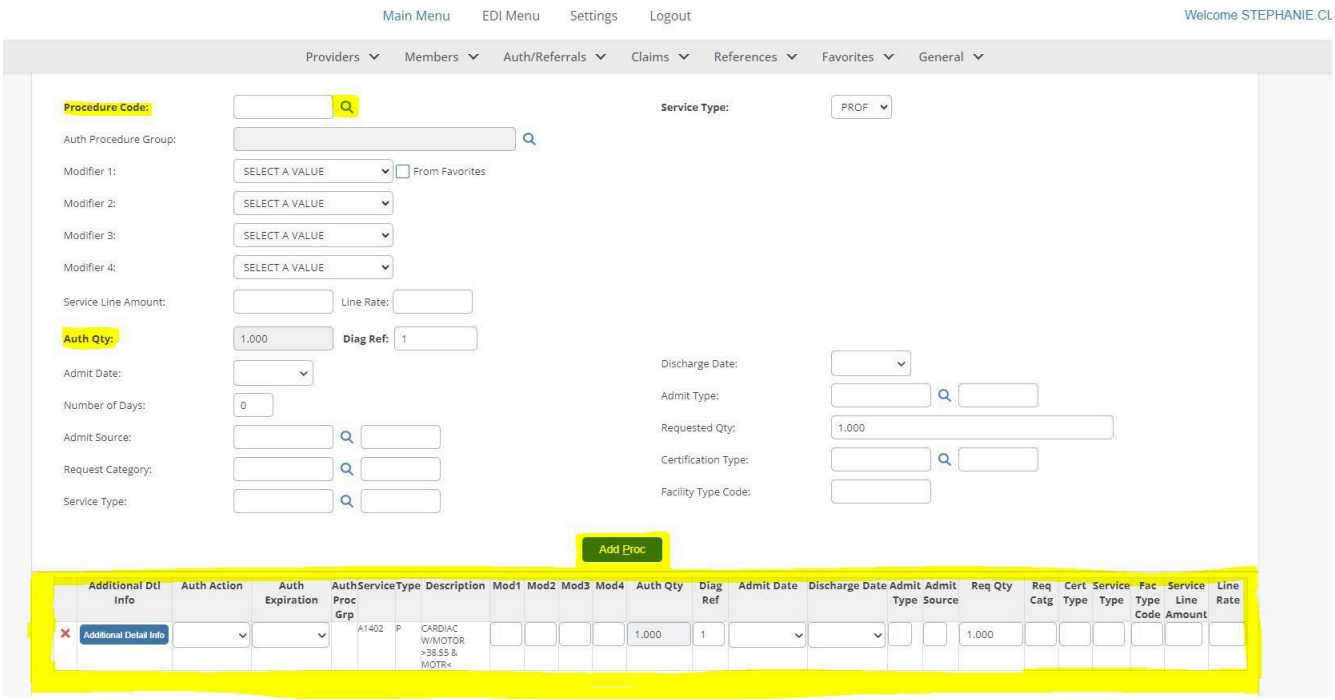
Authorization requests can be submitted by the user directly through the PROVIDER ADMINISTRATION PORTAL system. To begin a submission, click **Submission** in the **Auth/Referrals** section of the Main Menu to display the Authorization Submission window. Fill all the required fields and click on the


button to submit the request.



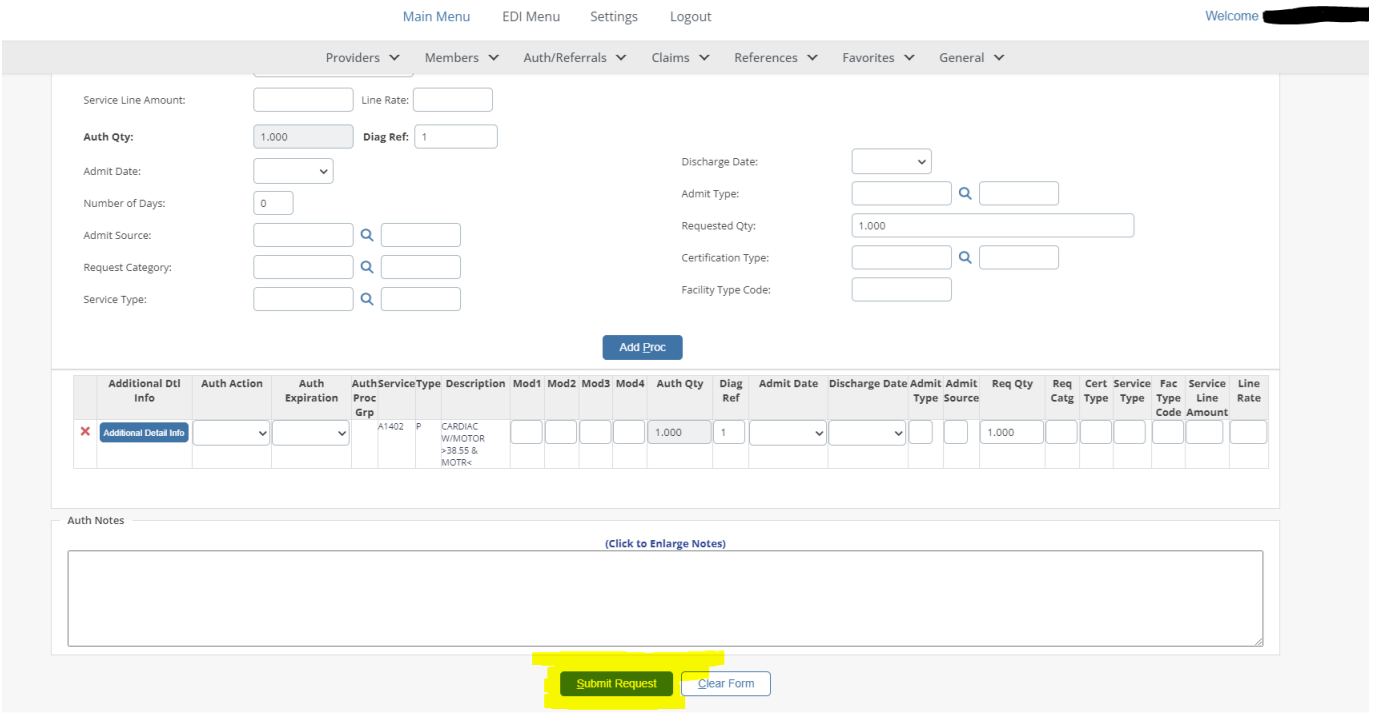

Main Menu
EDI Menu
Settings
Logout
Welcome S I
Providers
Members
Auth/Referrals
Claims
References
Favorites
General
Authorization Submission Entry
Additional Information
Diagnosis
Diagnosis Code:
I10
Number
Code
Version
LOINC Code
Diagnosis Code Search
Search
Clear
No of Records: 1
Ok
Cancel
Diagnosis Code:
I10
Description:
Version:
SELECT
Begins With
Contains
From Favorites
Code
Description
From Date
To Date
C/H
Version
I10
ESSENTIAL (PRIMARY) HYPERTENSION
10/1/2015
C
10
Page 1 GO> of 1 1 Total Item(s): 1 50
Auth Action:
Service Requested
Procedure Code:
Auth Procedure Group:
Modifier 1:
SELECT A VALUE
From Favorites
Modifier 2:
SELECT A VALUE
Modifier 3:
SELECT A VALUE
Modifier 4:
SELECT A VALUE


Main Menu
EDI Menu
Settings
Logout
Welcome STEPHANIE.CL
Providers
Members
Auth/Referrals
Claims
References
Favorites
General
Procedure Code:
Auth Procedure Group:
Modifier 1:
SELECT A VALUE
From Favorites
Modifier 2:
SELECT A VALUE
Modifier 3:
SELECT A VALUE
Modifier 4:
SELECT A VALUE
Service Line Amount:
Line Rate:
Auth Qty:
1.000
Diag Ref:
1
Admit Date:
Number of Days:
0
Admit Source:
Request Category:
Service Type:
Service Type:
PROF
Discharge Date:
Admit Type:
Requested Qty:
1.000
Certification 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
Service Line Amount
Line Rate
Additional Detail Info
A1402
P
CARDIAC W/MOTOR >38.55 & MOTR<
1.000
1
1.000

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

**Urgent:** 72 Hours (Medically necessary)

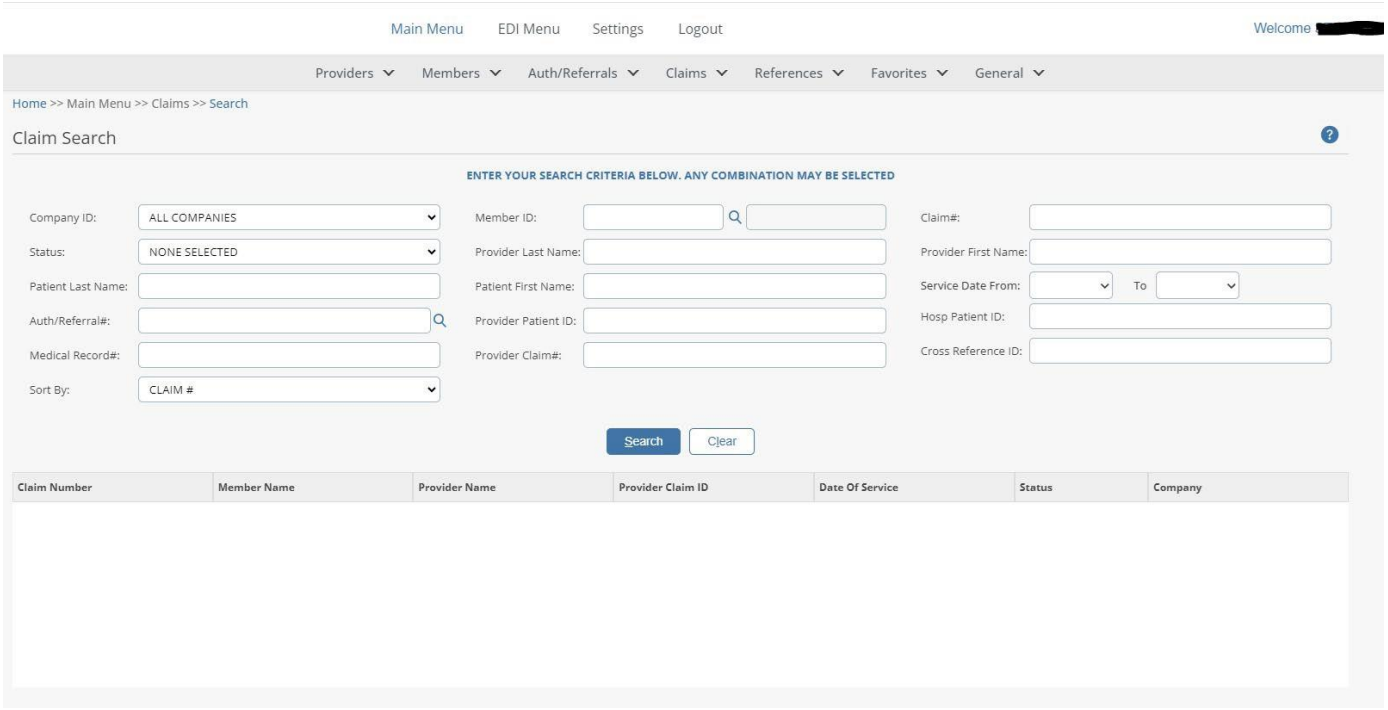
**Retro:** 30 Days

# Claims

## Inquiry

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

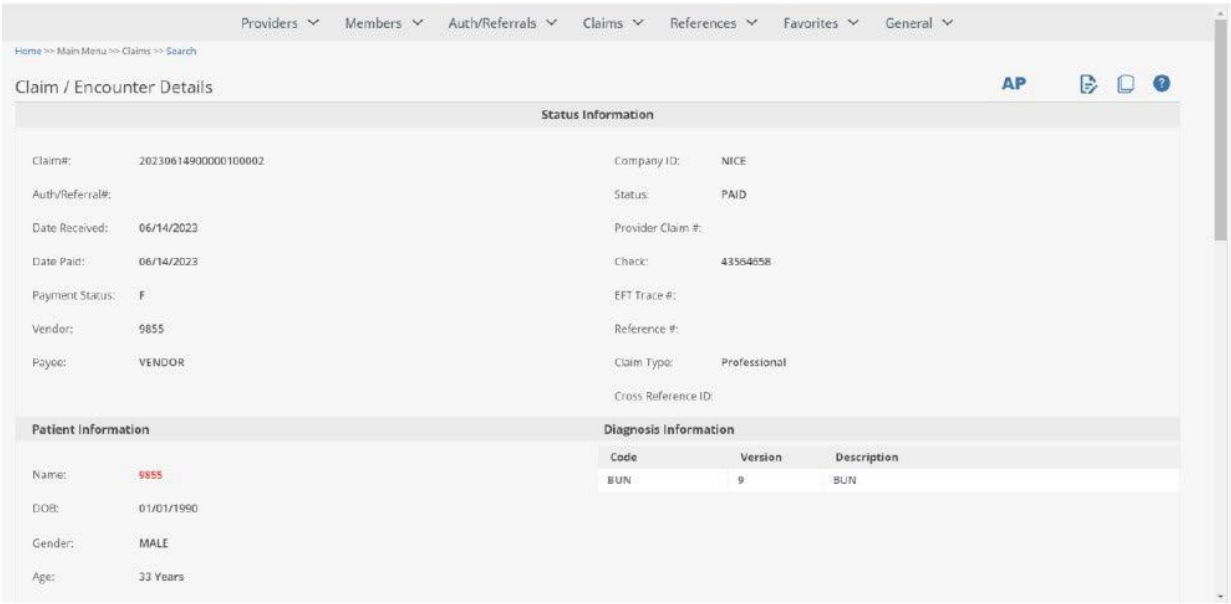
To begin an inquiry, click **Inquiry** in the Claims section of the Main Menu to display the Claim Search window.

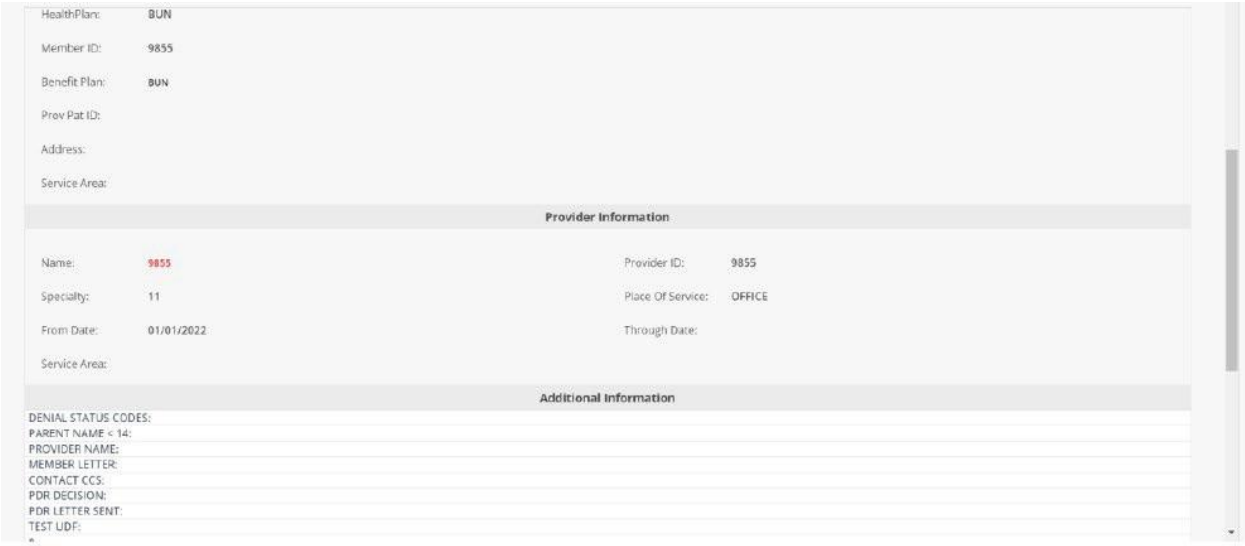



Click on the **Search** button. PROVIDER ADMINISTRATION PORTAL returns the Claim Search Results window, a grid displaying search results sorted in the specified order:

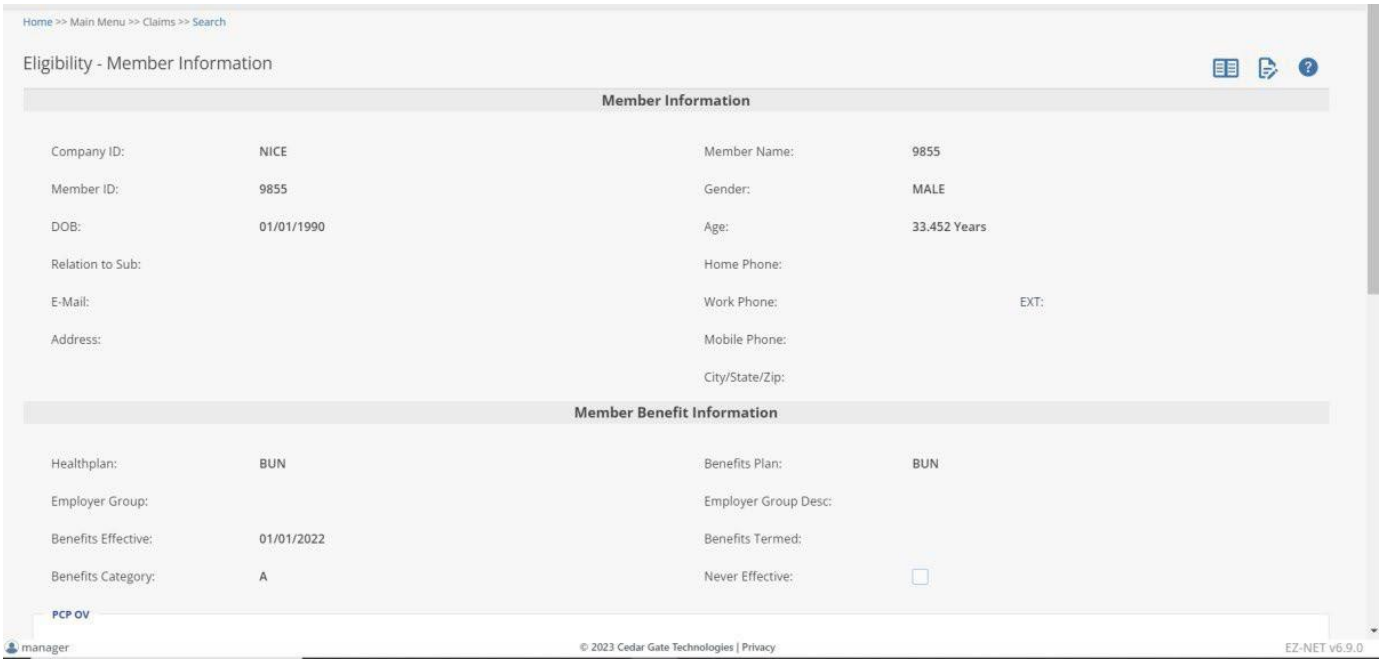
To display claim detail, click on the selected claim in the **"Claim #"** column (in BLUE text) in the Search Results window.

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




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


Home >> Main Menu >> Claims >> Search
Eligibility - Member Information
Member Information
Company ID: NICE
Member Name: 9855
Member ID: 9855
Gender: MALE
DOB: 01/01/1990
Age: 33.452 Years
Relation to Sub:
Home Phone:
E-Mail:
Work Phone:
EXT:
Address:
Mobile Phone:
City/State/Zip:
Member Benefit Information
Healthplan: BUN
Benefits Plan: BUN
Employer Group:
Employer Group Desc:
Benefits Effective: 01/01/2022
Benefits Termed:
Benefits Category: A
Never Effective:
PCP OV
manager
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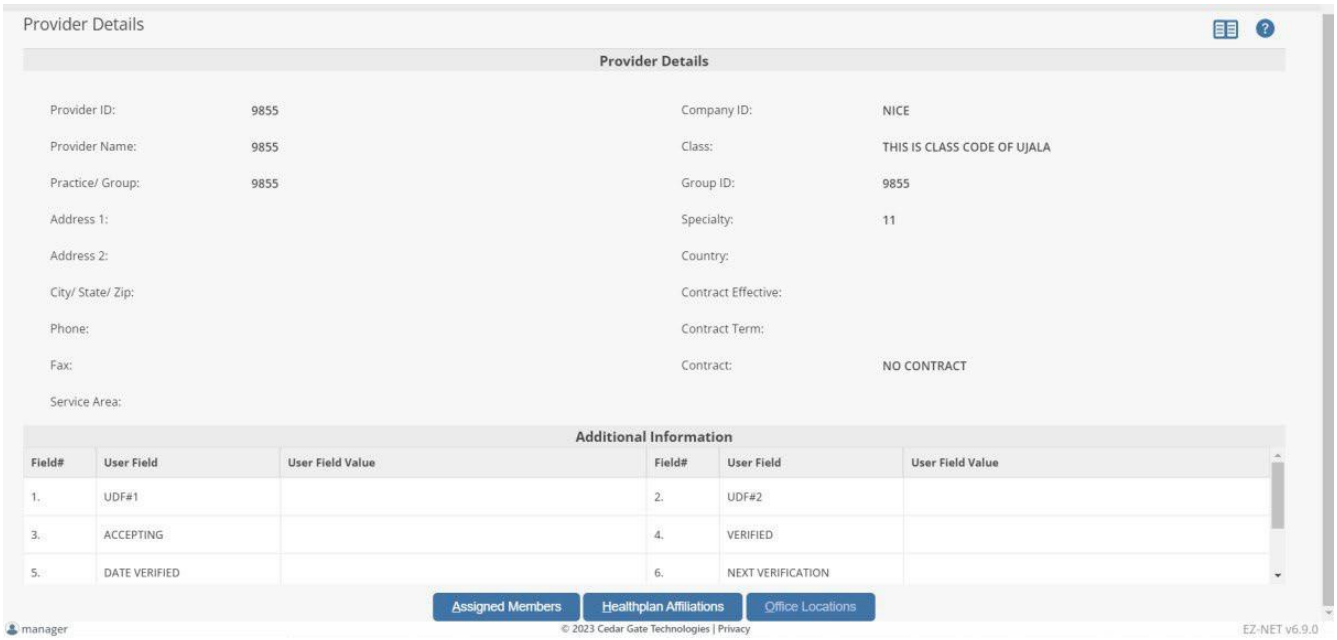
EZ-NET v6.9.0


Provider Details
Provider Details
Provider ID: 9855
Company ID: NICE
Provider Name: 9855
Class: THIS IS CLASS CODE OF UJALA
Practice/ Group: 9855
Group ID: 9855
Address 1:
Specialty: 11
Address 2:
Country:
City/ State/ Zip:
Contract Effective:
Phone:
Contract Term:
Fax:
Contract: NO CONTRACT
Service Area:
Additional Information
Field# User Field User Field Value Field# User Field User Field Value
1. UDF#1 2. UDF#2
3. ACCEPTING 4. VERIFIED
5. DATE VERIFIED 6. NEXT VERIFICATION
Assigned Members
Healthplan Affiliations
Office Locations
manager
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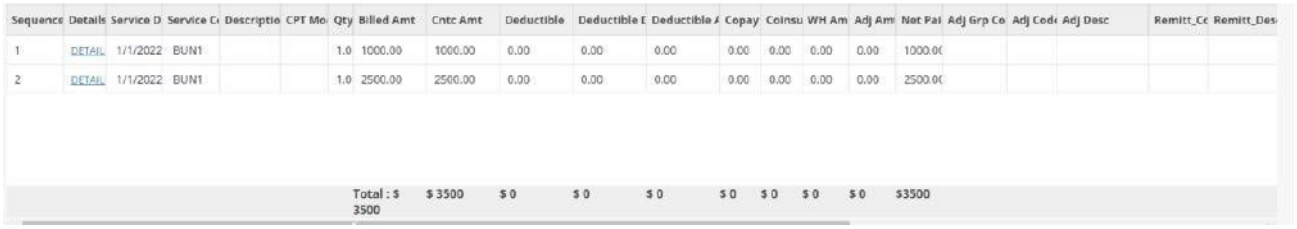
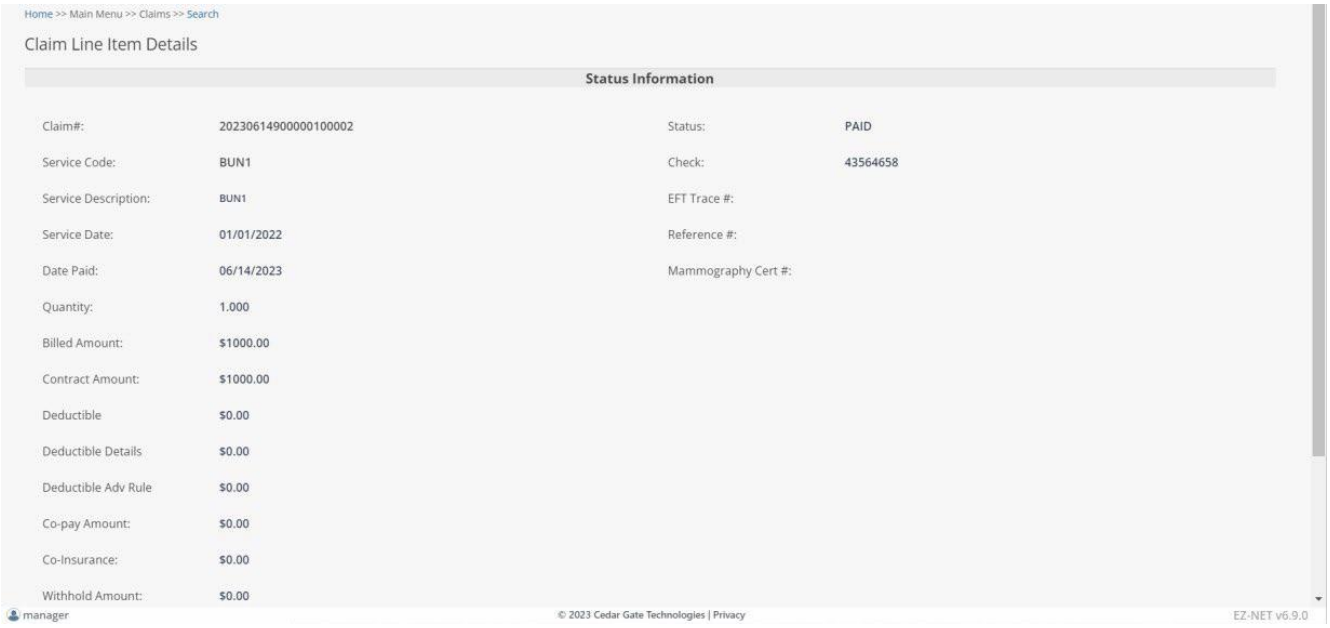
EZ-NET v6.9.0

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



| Sequence | Details | Service D | Service C | Descriptio | CPT Mo | Qty | Billed Amt | Cntc Amt | Deductible | Deductible E | Deductible A | Copay | Coinsu | WH Am | Adj Am | Net Pai | Adj Grp Co | Adj Code | Adj Desc | Remitt_Co | Remitt_Des |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | DETAIL | 1/1/2022 | BUN1 | | | 1.0 | 1000.00 | 1000.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1000.0( | | | | | |
| 2 | DETAIL | 1/1/2022 | BUN1 | | | 1.0 | 2500.00 | 2500.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2500.0( | | | | | |
| | | | | | | | Total : $ 3500 | $ 3500 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $3500 | | | | | |



IMPERIAL INSURANCE COMPANIES

2024 PROVIDER SATISFACTION SURVEY

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

## ADMINISTRATIVE SECTION

### Provider Network Operations

I have been supplied with:

**A Provider orientation** **YES ¨** **NO ¨**

**Access to the Web Portal** **YES ¨** **NO ¨**

2. My Provider Network Administrator is knowledgeable and able to answer my questions

Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨

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

Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨

### Claims

4. My claims are processed in a timely manner

**Strongly Agree ¨** **Agree ¨** **Disagree ¨** **Strongly Disagree ¨**

**Claims inquiries are answered promptly**

5. Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨

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

### Capitation

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

**Strongly Agree ¨** **Agree ¨** **Disagree ¨** **Strongly Disagree ¨**

8. My capitation payments I receive from IIC are accurate

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

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

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

## Utilization Management

10. UM Representatives are helpful

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

11. Referrals are processed in a timely manner

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

12. Denial notifications consistently provided denial reasons

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

## Credentialing

13. The Credentialing process occurred in a timely manner

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

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

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

15. Credentialing Coordinator is courteous and knowledgeable

**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

**Please provide additional comments or suggestions:**

_____

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

IMPERIAL HEALTH PLAN
OF THE SOUTHWEST

2024 PROVIDER SATISFACTION SURVEY

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## ADMINISTRATIVE SECTION

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**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

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**Strongly Agree ¨ Agree ¨ Disagree ¨ Strongly Disagree ¨**

**Please provide additional comments or suggestions:**

_____

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