Imperial Health Plan of California, Inc.

and

Imperial Health Holdings Medical Group, Inc.

Provider Manual 2025

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SECTION 1. INTRODUCTION

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

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

Imperial is overseen by an executive board, a Chief Medical Officer and a Quality Management Committee, and other committees that oversee the care provided to Imperial's members.

1.2 Quality Management Committee

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

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.

UM staff are familiar with pre-authorization processes required by Imperial's current policy and procedure. Imperial's policy is to expedite referral requests from providers by processing them within 1-2 working days. UM responsibilities include:

- Implementation of UM Program and Work Plan;
- UM reporting required for Imperial;
- Preparation for and participation in Imperial UM audits;
- Hospital Case Management;
- After-hours triage; and
- Other services as required by Imperial Health Plan (IHPCA) or Imperial Health Holdings (IHHMG), 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.

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

QI program is structured to include the following functional areas and their responsibilities:

- QI Staff: Collects and analyzes data, develops and implements QI initiatives.
- QI Committee: Oversees the QI program, analyzes data, and recommends improvements.
  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.
- Physician Advisor: Provides clinical expertise and guidance to the QI Committee.
  Advisor's responsibilities include:
  - Reviewing QI data.
  - Identifying opportunities for improvement.
  - Developing and implementing QI initiatives

Annual Work Plan and Evaluation

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

The work plan is developed with input from stakeholders and is reviewed and approved by the QI Committee.

The work plan includes:

- a time frame for completion of each activity,
- the staff members responsible,
- a process for monitoring previously identified issues.

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

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

The evaluation includes:

- a description of completed and ongoing QI activities,
- trending of performance measures,
- and an assessment of the program's overall effectiveness in improving the quality and safety of clinical care.

1.3 **Provider Network Management**

Provider Network Management (PNM) is committed to being accessible to all contracted providers daily.

Network Administrators are responsible for provider education, provider concern resolution as well provider contracting and provider retention

PNM shall work 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, and QM;
- Issue resolutions 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) 830-3901
- Email: pnm@imperialhealthholdings.com

1.4 Credentialing

The Credentialing Department maintains provider credentialing files in compliance with standards recognized and mandated by the NCQA, Imperial, and other accrediting agencies. 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. The organization recredentials all providers every three years. The recredentialing process includes a review of the provider's performance, including quality of care, member satisfaction, and compliance with the organization's policies and procedures.

1.5 Enrollment and Eligibility

The Enrollment and Eligibility and administers and reconciles eligibility.

The Enrollment and Eligibility Department manages electronic eligibility lists for Imperial, prepares eligibility lists for Primary Care Providers (PCPs), and oversees the administration and reconciliation of eligibility.

1.6 Claims and Encounter Data Processing

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

SECTION 2. IMPORTANT CONTACT NUMBERS

2.1 Imperial Contact Numbers

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

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

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

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

2.2 **Other Contact Numbers**

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

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

SECTION 3. RESPONSIBILITIES OF IMPERIAL'S CONTRACTED PROVIDERS

3.1 **Medical Services Covered under Primary Care**

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

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

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

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

Dermatology

• Treat acne (acute and recurrent) • Treat painful or disabling warts with topical suspensions, electrocautery, liquid nitrogen. • Diagnose and treat common rashes including: contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor • Screen for basal or squamous cell carcinomas. • Biopsy suspicious lesions (if trained may do biopsy of suspicious lesions for cancer or others such as actinic keratoses) • Punch biopsy • Incisional biopsy	• Diagnose and treat common hair and nail problems and dermal injuries. • Common hair problems include: fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects • Common nail problems include: trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails • Dermal injuries include: minor burns, lacerations, and treatment of bites and stings • Counsel patients regarding removal of cosmetic (non-covered) lesions. • Identify suspicious moles
Endocrinology	
• Diabetic management, including Type I and Type II, for most patients. • Patient education • Supervision of self-blood glucose monitoring (SBGM) testing • Medication management • Manage diabetic ketoacidosis (DKA) • Manage thyroid nodules (testing, radiological imaging)	• Diagnose and treat thyroid disorders • Identify and treat hyperlipidemia • Diet instruction • Exercise instruction • Provide patient education for osteoporosis risk factors • Identify and treat lipid disorders with diet and/or at least two medications for a minimum of six months
Gastroenterology	
• Diagnose and treat lower abdominal pain • Diagnose and treat acute diarrhea • Occult blood testing • Perform flexible sigmoidoscopy • Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease • Evaluate acute abdominal pain	• Diagnose and treat uncomplicated inflammatory bowel disease • Diagnose jaundice • Diagnose and treat ascites • Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids • Manage functional bowel disease • Manage diagnosed malabsorption syndrome • Manage mild hepatitis A
General Surgery	
• Evaluate and follow small breast lumps in teenagers • Order screening mammograms • Aspirate cysts • Foreign body removal	• Laceration repairs (minor) • Local minor surgery for hemorrhoids • Minor surgical procedures • Diagnose gallbladder disease • Manage inguinal hernia
Geriatrics	
• Diagnose and treat impaired cognition (dementia) • Be familiar with effects of aging on drug distribution, drug metabolism, and drug-drug interaction	• Management of advanced illness including the use of alternative levels of care • Recognition of elder abuse
Obstetrics and Gynecology (OB/GYN)	

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

• Coordinate care for patients recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist	• Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA, AFO for foot drop
Psychiatry	
• Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)	• Diagnose physical disorders with behavioral manifestation • Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist • Diagnose and manage child, elder, dependent adult abuse, and domestic violence victims
Pulmonology	
• Diagnose and treat asthma, acute bronchitis, pneumonia • Diagnose and treat chronic bronchitis • Diagnose and treat chronic obstructive pulmonary disease	• Manage home aerosol medications and oxygen • Work up possible tuberculosis or fungal infections • Treat opportunistic infection • Order chest x-rays, special views, and CT scans
Rheumatology	
• Diagnose and treat non-articular musculoskeletal problems: > Overuse syndromes > Injuries and trauma > Soft tissue syndromes > Bursitis or tendonitis • Provide steroid injections • Manage osteoarthritis unless there is a significant functional impairment despite treatment	• Diagnose crystal diseases • Perform arthrocentesis • Diagnose and treat rheumatoid arthritis • Diagnose and treat inflammatory arthritic diseases • Diagnose and treat uncomplicated collagen diseases
Urology and Nephrology	
• Diagnose and treat initial and recurrent urinary tract infections (UTIs) • Provide long term chemoprophylaxis • Diagnose and treat urethritis • Explain hematospermia • Initiate evaluation of hematuria • Evaluate incontinence • Evaluate male factor infertility and impotence and treat readily correctable factors	• Diagnose and treat epididymitis and prostatitis • Differentiate scrotal or peri testicular masses from testicular masses • Evaluate prostatism and prostatic nodules • Manage urinary stones • Evaluate and treat renal failure • Placement of urinary catheters • Evaluate impotence • Evaluate male infertility
Vascular Surgery	
• Diagnose abdominal aortic aneurysm • Diagnose and treat venous diseases • Treat stasis ulcers	• Manage intermittent claudication • Manage transient ischemic attacks • Manage asymptomatic bruits
Other	
• Basic life support • Advanced life support • Heimlich maneuver	• Endotracheal intubation • Tracheostomy (emergency) • Cardiopulmonary resuscitation (CPR)

3.2 Role of Specialty Care Physicians

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

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

NOTE:

Specialists can only submit referral authorization requests, through the PCP, for additional continued care or treatment of members and cannot refer members to other specialists. Unauthorized services will not be reimbursed.

Specialists must notify Imperial to arrange for a Memorandum of Understanding to be in place when a non-participating provider is scheduled to take calls for the specialist or assist the specialist with a service or procedure. The use of a call answering machine is not an acceptable form of on-call coverage.

3.3 Appointments and Services

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

Type of Appointment and Services	Access Standards and Requirements
PCP Availability	• PCP must be available by telephone 24/7. • If the PCP is unable to provide on-call services, arrangements must be in place to cover the PCP after hours and on weekends; covering physician must be credentialed by Imperial.
Appointment Scheduling Systems	• Providers should use an efficient and effective written or computerized appointment scheduling system, which includes follow-up on canceled appointments.
In-Office Waiting Time	• The waiting time for scheduled appointments should be reasonable and within community standards.

Appointments for Urgent and Routine Primary Care Services	• For **urgent primary care services**, PCPs are required to triage and provide **same-day appointments** for members. • For routine primary care services, the maximum timeline for appointments is as follows: 1. Physical exams and routine preventive services: 4 work weeks. 2. Routine ambulatory visits: 7 business days.
Appointments for Routine Physician Consultations and Specialty Referrals	• Specialists must schedule an appointment for non-urgent, properly authorized referrals within 15 calendar days.
Appointments for Routine Prenatal Care	• Members in their first or second trimester: initial appointments must be available within one week from the date of the member's request. • Members in their third trimester and/or identified as "high risk": initial appointments must be made within 3 days of the member's request.
90-day Initial Health Assessment (IHA)	• Each newly enrolled member is expected to receive an IHA within 90 days of enrollment.
Type of Appointment and Services	**Access Standards and Requirements**
Appointment for Sensitive Services	• Sensitive services must be made available to members within two days of the member's request for appointment. Sensitive services include services related to mental or behavior health, sexual and reproductive health, sexually transmitted infections, substance abuse, gender-affirming care, and intimate partner violence. • Sensitive services will be provided under the following conditions: 1. For minors 12 years of age and older: without necessity of preauthorization, referral, or parental consent. 2. For all members: confidentially, in a manner that respects the member's privacy and dignity.

3.4 **Telephone Access**

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

3.5 **Services for Members with Disabilities**

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

TDD/TTY Access for the Hearing Impaired in California is 711.

3.6 Interpreter Services

- PCPs and specialists are required to offer interpreter services to members with Limited English Proficiency (LEP) to provide quality health care services.
- Members should not be asked to use their own interpreters or to use family, friends, or minors to interpret.
- If a member declines interpreter services, the provider must note this in the member's medical record.
- Imperial providers must provide interpreter services 24/7 through Imperial's contracted language lines. Providers can access language lines if requested by the member in his/her language. After- hours phone services staff should be instructed on how to connect with the language line.
- If a patient has LEP and requires language assistance, contact (855) 886-2901.
- See section 9.2 for additional information on the Language Assistance Program and Culturally and Linguistically Appropriate Services requirements.

3.7 Credentialing and Facility Site Review

Imperial Health Plan does not perform facility site reviews as part of the credentialing process. Quality and safety of care are ensured through other established mechanisms, including practitioner credentialing and adherence to evidence-based guidelines.

Recredentialing reviews are conducted every three (3) years unless the Credentialing Committee approves a shorter recredentialing period based on specific circumstances.

Imperial Health Plan ensures that all credentialing and recredentialing decisions are made based on established criteria and are non-discriminatory in compliance with applicable laws and regulations.

The following documents are required for the initial credentialing process:

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

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

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

A. Provider Status Change

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

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

B. Required Reporting

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

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

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

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

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

3.10 **Vaccine and Immunization Administration**

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

SECTION 4. DATA AND CLAIMS SUBMISSION

4.1 **Claims Submission**

Industry standards require that all claims be submitted within 60 calendar days, or as defined in your provider services agreement following the end of the month, and no later than 90 days from when care was rendered. Claims will be processed, and payments made in accordance with the Timeliness Guidelines promulgated pursuant to the CMS Medicare Program. Claims should be submitted to Imperial for services performed by the physician according to the contract. Imperial will only accept claims submitted on an industry standard CMS 1500 or UB04 Claim Form.

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

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

- Patient's name and date of birth;
- Patient's insurance identification number;
- Patient's complete address;
- Date of onset of illness or injury (or last menstrual period where applicable);

- ICD-10 diagnosis code(s) and procedure and modifier code(s) (CPT or HCPCS);
- Referring physician;
- Date(s) of service, place of service, type of service, quantity/unit of service(s), and normal charges;
- Authorization number in Box 23 (when required);
- The Physician's Federal Tax ID number, Medicare Provider number, and NPI number (where applicable);
- Name and address of facility where services were rendered;
- Name, address, zip code, and phone number of Physician submitter;
- Attached OR, ER notes and medical reports for E&M codes billed as complex or severe;
- A copy of the authorized referral attached to the claim (when required); and
- EOMB or EOB attached if other coverage (COB) applies.

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

Imperial Health Plan of California, Inc.

Claims Department
PO Box 60874
Pasadena, CA 91116-6874

Imperial Health Holdings Medical Group, Inc.
Claims Department
PO Box 60075
Pasadena CA 91116

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

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

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

Please refer to the Compensation Fee Schedule within your Provider Agreement to determine the payment amount you will receive for services rendered. All payable claims shall be processed in accordance with the applicable fee schedules and guidelines promulgated by each government program. Medicare Advantage HMO claims shall be paid in accordance with the prevailing Medicare fee schedule and the claims processing and payment guidelines as established by CMS.

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

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

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

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

SECTION 5. ENROLLMENT AND ELIGIBILITY

5.1 Eligibility Verification

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

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

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

5.2 Eligibility List

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

5.3 Member Disenrollment

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

Medicare Advantage SNP members have the option to change Plans on a month-to-month basis. PCPs are encouraged to promptly establish a patient-physician relationship with all Imperial members to promote continuity of care and to address and promptly resolve any health care needs or concerns of the patient.

5.4 Provider Status Change

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

SECTION 6. REFERRALS

6.1 Referral Authorization Process and Guideline

PCPs are responsible for obtaining an authorization when referring a patient for specialty services. (Refer to the Forms Section 17 for General Referral Form).

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

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

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

6.2 Referral Submission Process for Routine and Urgent Referrals

Use Imperial's provider portal to submit online referrals. Please upload pertinent clinical documentation (e.g., progress notes, diagnostic test results, medications, and treatments for medical necessity reviews). For provider portal support and assistance, please contact (800) 830-3901.

General Referral Form in Section 14 can be used and may be faxed to Imperial's UM Department at (888) 910-4412.

The following information must be provided to avoid unnecessary delays:

- Member's name;
- Member ID number;
- Specialist's name;
- Reason for referral (provide all pertinent progress notes which may include diagnostic test results, medications or treatments tried);
- Number of visits requested; and
- CPT and ICD-10 codes.

6.3 Guidelines on Authorization Turn-Around Time

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

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

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

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

6.4 **Approved Referrals**

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

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

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

6.5 **Denied Referrals**

Imperial's UM Department will mail a letter to the patient and the provider informing them of any denial and providing information on the Appeal Process. The UM department also sends a copy of the denial letter to the PCP, including the medical policy criterion for the denial. The PCP must file this letter in the member's medical record.

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

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

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

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

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

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

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

If contacted by the Member, the PCP or his/her on call physician is responsible for determining the medical necessity of an urgent care or emergency room (ER) visit. After hours, urgent care referrals should be directed to the contracted urgent care centers (listed on Provider Rosters):An acute care facility, urgent care clinic or any emergency room cannot be used to provide primary care services in lieu of the PCP's office. The PCP may refer members to an ER when an emergency or urgent condition exists. The protocols for ER referrals and care coordination are as follows:

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

- For an inpatient admission, the ER staff should obtain an authorization from the PCP. If the PCP does not have admitting privileges at the hospital, the PCP should call the admitting physician.

Procedure for Emergent Referrals:

1. Make sure the General Referral Form contains the following information: member's name, reason for referral, member ID number, number of visits requested, specialist's name, CPT and ICD-10 codes.
2. Fax a copy of the General Referral Form to Imperial's UM department at (888) 901-2526. 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 (800) 708- 8273 of any ER visit or emergency inpatient admission on the business day following notification by the Member, ER, or admitting facility.

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

6.7 Process for Requesting Physician Assisted Drugs (PADs)

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.

SECTION 7. CASE MANAGEMENT PROGRAM

7.1 Case Management Referrals/Eligibility Criteria for Case Management Referrals

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.

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 and or:
    - Medication non-adherence
    - Concurrent use of 2 or more anticholinergic prescriptions
    - Concurrent use of Opioids and Benzodiazepines
- Two or more emergency room visits in a 6-month period;
- Two or more admissions within a 12-month period;
- Re-admission within 30 days with the same or similar diagnosis or condition; and
- Cancer diagnosis requiring multiple treatment modalities with care coordination across multiple disciplines.

SECTION 8. HEALTH RISK ASSESSMENT

8.1 Health Risk Assessments (HRA)

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

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

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

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

SECTION 9. NON-COVERED PROGRAM SERVICES

9.1 Non-Covered Medicare Advantage Services

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

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

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

9.2 Non-Covered Other Lines of Business Services

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

SECTION 10. LINKED AND CARVED OUT MEDICARE SERVICES

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

For the Medicare Advantage Program:

- Dental Services;
- Optometry Benefits; and
- Prescription Drugs – Medicare Part D.

SECTION 11. MEMBER HEALTH EDUCATION AND LANGUAGE ASSISTANCE

11.1 Advance Directives

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

The responsibility of the PCP is as follows:

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

11.2 Language Assistance Program

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

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.

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

Interpreter services at Provider Sites:

- Providers must document the member’s preferred language in the member’s medical record.
- Providers must offer interpreter services to members with LEP or who are deaf, hard of hearing, or speech impaired at no cost to the members.

- Members are not required to provide their own interpreters or use family members or friends as interpreters. Minors should not interpret for adults. The use of family, friends, and/or minors may compromise the reliability of medical information. Use of these people could also result in a breach of confidentiality or reluctance on the part of the members to reveal personal information critical to their situations.

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

Translations and Materials in Alternative Format

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

SECTION 12. COMPLAINTS AND GRIEVANCES

12.1 Member Complaints and Grievances

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

- Members must be informed of their right to complain and may submit complaints orally or in writing to Imperial.
- Members should be directed to call Imperial's Member Services Department (800-838-8271) to file a grievance.
- Members can obtain a complaint form, either from their provider's office or Imperial's website, IR_450-H5496-Grievance-Form-_C-ENG-11.08.23.pdf
- Imperial is required to acknowledge a member's complaint and resolve the member's complaint within thirty (30) calendar days.

- Members can call Imperial, CMS, and/or the state HHS department if the complaint is not resolved to their satisfaction.
- Providers are expected to respond to grievance resolution requests in a timely manner, typically within two business days. Providers are expected to provide a complete response to all issues raised, including any requested records.
- Providers may not terminate members for filing a complaint.

Common reasons for grievances include:

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

12.2 **Provider Complaints**

Providers are encouraged to aid in the overall quality improvement efforts of the provider network by bringing forth issues that affect members' care, operational issues, or other service problems.

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

12.3 **Claims Settlement & Grievance Practices**

Provisions under HHS provide for fast, fair, and cost-effective dispute resolution mechanisms for claim disputes. Imperial will process claim disputes under its Provider (Claim) Dispute Resolution Policy & Procedure guidelines. Disputes must be submitted in a written format that clearly documents and identifies the issue in dispute. (Refer to the following "Downstream Provider Notice" for full disclosure and instructions). Contracted provider claim disputes should <u>not</u> be sent to the Appeals and Grievances department.

Claims grievances for the Medicare Advantage Program are processed under CMS regulatory guidelines and shall adhere to the timelines for receipt and response as promulgated.

12.4 **Member and Provider Satisfaction Surveys**

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

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

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

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

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

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

SECTION 13. COMPLIANCE

13.2 Code of Conduct and Business Ethics

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

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

13.3 Compliance Program

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

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

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

13.4 Fraud, Waste and Abuse Compliance

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

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

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

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

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

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

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

13.5 HIPAA Privacy Practice Notice Guidelines

A. Background

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

Although consumers trust their caregivers to maintain the privacy of their health information, they are often skeptical about the security of their information when it is placed on computers or disclosed to others.

Increasingly, consumers want to be informed about what information is collected, and to have some control over how their information is used.

B. Federal Requirements

Standards for Privacy of Individually Identifiable Health Information

In general, the federal Standards for Privacy of Individually Identifiable Health Information, also known as the HIPAA Privacy Rule (45 CFR Part 160-164) requires that:

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

In general, the content of the notice must contain:

1. A header: "THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.";
2. A description, including at least one example of the types of uses and disclosures that the covered entity is permitted to make for treatment, payment, and healthcare operations;
3. A description of each of the other purposes for which the covered entity is permitted or required to use or disclose protected health information without the individual's written consent or authorization;
4. A statement that other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization;
5. When applicable, separate statements that the covered entity may do the following: 1) contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual; 2) raise funds for the covered entity; and 3) that the group health plan or health insurance issuer or HMO may disclose protected health information to the sponsor of the plan;
6. A statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, including:
    - the right to request restrictions on certain uses and disclosures as provided by 45 CFR 164.522(a), including a statement that the covered entity is not required to agree to a requested restriction;
    - the right to receive confidential communications of protected health information as provided by 164.522(b), as applicable;
    - the right to inspect and copy protected health information as provided by 164.524;
    - the right to amend protected health information as provided in 164.526;

- the right to receive an accounting of disclosures as provided in 164.528; and
- the right to obtain a paper copy of the notice upon request as provided in 164.520;

7. A statement that the covered entity is required by law to maintain the privacy of protected health information and to provide individuals with notice of their legal duties and privacy practices with respect to protected health information;
8. A statement that the covered entity is required to abide by the terms of the notice currently in effect;
9. A statement that the covered entity reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains;
10. A statement describing how it will provide individuals with a revised notice;
11. A statement that individuals may complain to the covered entity and to the Secretary of Health and Human Services if they believe their privacy rights have been violated; a brief description as to how one files a complaint with the covered entity; and a statement that the individual will not be retaliated against for filing a complaint;
12. The name or title and telephone number of a person or office to contact for further information; and
13. An effective date, which may not be earlier than the date on which the notice is printed or otherwise published.

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

SECTION 14. Quality Management Program

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

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

14.1 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.

14.2 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 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.

14.3 Goals and Objectives

Continually improve member experiences by measuring outcomes, and continuously improve all aspects of the healthcare continuum. 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. 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, needed.

14.4 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

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.

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.

14.5 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 feedback 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 IHPCA & IHHMG.

14.6 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.

Imperial Health Plan conducts regular audits of delegated entities' credentialing processes to ensure compliance with NCQA standards, including timeliness and adherence to established policies.

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.

14.7 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.

14.8 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.

14.9 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 to by the health plans.

Credentialing

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

Structure

The credentialing committee is composed of multidisciplinary participating PCPs or specialist 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 committee 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. Imperial Health Plan conducts regular audits of delegated entities' credentialing processes to ensure compliance with NCQA standards, including timeliness and adherence to established policies.

Imperial Health Plan ensures that all credentialing and recredentialing decisions are made based on established criteria and are non-discriminatory in compliance with applicable laws and regulations.

Recredentialing reviews are conducted every three (3) years unless the Credentialing Committee approves a shorter recredentialing period based on specific circumstances.

14.10 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.

14.11 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.

14.12 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 underutilization;
- 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.

14.13 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 people.

14.14 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.

14.15 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.

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

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

14.17 Pre-Delegation Assessment / Evaluation

Imperial conducts pre-delegation evaluation prior to implementing delegation.

14.18 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.

14.19 Communication to Imperial's Providers & Delegates

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

- Members 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.

14.20 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.

14.21 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.

14.22 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.

14.23 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.

14.24 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.

14.25 Annual QM Program Evaluation

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

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

SECTION 15. PROVIDER AND HOSPITAL ROSTER

15.1 Laboratory

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

15.2 Contracted Hospital Facilities

Imperial uses contracted hospital and inpatient facilities (skilled nursing, rehab, etc.). 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.

SECTION 16. CLAIMS

Overview:
The focus of Imperial's claims department is to ensure claims are processed timely and accurately and in accordance with state and federal regulations. Imperial has established a toll-free telephone number for providers to access a representative in the customer service department. Providers may call (626) 708-0333 and select option 3 for claims.

Timely Claims Submission:
Clean claims for Medicare members are completed within 30-calendar days and 60-calendar days for contracted

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

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

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

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

Imperial Health Plan of California	Via Mail: P.O. Box 60874 Pasadena, CA 91116-6874
	Via Clearinghouse: Office Ally Payer Code: IHP01
Imperial Health Holdings Medical Group	Via Mail: P.O. Box 60075 Pasadena, CA. 91116-6874
	Via Clearinghouse: Office Ally Payer Code: IHHMG

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

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

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

Claim Format:
The standard CMS required forms and data elements can be found in the CMS claims processing manual located at https://www.cms.gov/manuals/downloads/clm104c12.pdf. Appropriate forms and data elements must be present for a claim to be considered a clean claim.

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

Billing and balance billing members
You may bill or charge Imperial members for applicable copayments, coinsurance and/or deductibles. Your provider agreement addresses the circumstances under which you can bill Imperial members. However, Imperial wants to protect our members from unnecessary or inappropriate billing.
Therefore, you may not balance bill members when claims are denied for administrative reasons, such as lack of referral or authorization when one is required.

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

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

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

If the provider contests Imperial's notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to Imperial stating the basis upon which the provider believes the claim was not overpaid. Imperial will process the contested notice in accordance with Imperial's contracted provider dispute resolution process described in Section 16.2 above.

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

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

Coordination of Benefits

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

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

Members under the Medicare Advantage line of business may be covered under more than one insurance policy at a time. In the event that Imperial has information on file to suggest the member has other insurance primary to Imperial, Imperial may deny the claim. If the primary insurance has terminated, the provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the provider is responsible for submitting the initial claim with proof that payment has been returned to the primary insurance carrier.

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

16.3 Payment Disputes:

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Imperial in writing within 90 calendar days of the date of denial set forth in the EOP.

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

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

Reimbursement

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

Surgical Payments

Reimbursement to a surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care.

The following claims payment policies apply to surgical services:

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

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

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

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

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

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

Modifiers

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

16.4 Virtual Examiner

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

A key regulatory mandate was the implementation of the Correct Coding Initiative edits into claims processing for all Medicaid and Medicare Managed Care Plans. One of the goals of Imperial's compliance program is to focus on areas under government inspection and review. When investigating fraud and abuse, federal and state agents are looking at the following areas: unbundling, up-coding, medically unnecessary services, duplicate billing, and billing for services not rendered.

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

SECTION 17. OFFICE ALLY & ONLINE SERVICES

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

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

Our on-line features include:

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

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.

To set up an account with Imperial's web portal, contact us by phone at (626) 838-5100, extension 7 (portal assistance).

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

Please note our payer ID's:

Imperial Health Plan of CA is: IHP01

Imperial Health Holdings Medical Group: IHHMG

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

SECTION 18. PATIENT'S/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.

18.1 Distribution of Rights

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.

Our 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 1-800-838-8271 October 1 – March 31: Monday – Sunday, from 6:00 a.m. – 8:00 p.m. PST April 1 – September 30: Monday – Friday, from 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. Refer to Chapter 8: Rights and Responsibilities in your Evidence of Coverage.

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

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. Your Evidence of Coverage (EOC_, Chapter 3 explains more about this. Call Member Services at the number listed in section 1.1 above 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 Part D drugs within a reasonable amount of time, your EOC Chapter 9, Section 10 tells what you can do. If we have denied coverage for your medical care or drugs and you don't agree with our decision, your EOC Chapter 9, Section 4 tells what you can do.

18.2 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.

It is the Patient's Right to:

1. Members/patients have the right to receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities.
2. 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;
3. Members also have the right to be treated with respect. We must treat you with respect and recognition of your dignity and protect the privacy of your personal health information. Considerate and respectful care, as follows:

   You will always be treated with respect and dignity.

   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;

4. 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;

      (iv)

5. 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;

6. 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;

7. 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;

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

9. To personal privacy and confidentiality of information;

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.

a. 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.
b. The laws that protect your privacy give you rights related to getting information and controlling how your health information is used.

How do we protect the privacy of your health information?

a. We make sure that unauthorized people don't see or change your records.
b. 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.
c. There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

(i) For example, we are required to release health information to government agencies that are checking on quality of care.
(ii) Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal 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 Imperial's **Member Services Department (800-838-8271)**.

10. Access information contained in the patient's medical record, within the limits of the law; and the right of the patient's guardian, next of kin, or legally authorized responsible person to exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient:

    a. has been adjudicated incompetent in accordance with the law;

    b. is found by his or her physician to be medically incapable of understanding the proposed treatment or procedure;

    c. is unable to communicate his or her wishes regarding treatment; or

    d. is a minor;

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

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

13. Contact his/her physician or health plan with any questions or concerns about health benefits or health care services;

14. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.

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

As a member of Imperial Health Plan of California. Inc., you have the right to get several kinds of information from us. As explained above in Section 1.1, 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 the number listed above:

- **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 and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - o 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.
  - o 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 also available on our website at www.imperialhealthplan.com. You can also Member Services for detailed information about providers or pharmacies at (800-838-8271).
- **Information about your coverage and the rules you must follow when using your coverage.**
  - Your EOC Chapters 3 and 4 we explain 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 your Part D prescription drug coverage, your EOC Chapters 5 and 6 List of

Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

- If you have questions about the rules or restrictions, please call Member Services at the number listed above.

- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D 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 Part D drug is covered for you, 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, see your EOC Chapter 9. It gives you the details about how to make an appeal if you want us to change our decision. Your EOC Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see your EOC Chapter 7.

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 of 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. See your EOC Chapter 9 that tells you how to ask the plan for a coverage decision.

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 names 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. You can sometimes get advance directive forms from organizations that give people information about Medicare.

You can also contact Member Services to ask for the forms at the number listed above.

- **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.
- **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). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, your EOC Chapter 9 of tells

what you can do. It 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 Department (800-838-8271)**.

What can you do if you believe you are being treated unfairly or your rights are not being respected?

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.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** at the number listed in section 1.1 above
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see your EOC Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights
There are several places where you can get more information about your rights:

- You can **call Member Services** at the number listed in section 1.1 above
- You can **call the SHIP**. For details about this organization and how to contact it, see your EOC Chapter 2, Section 3.
- You can contact **Medicare**.
    - o You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - o Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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 the number listed in section 1.1 above. We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this EOC 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 EOC is also posted on our website at www.imperialhealthplan.com.

o EOC Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
o EOC Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services at the number listed in section 1.1 above to let us know.

  o We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go your EOC Chapter 1, Section 10.)

- **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 or Part D 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.**
  - o To help your doctors and other health providers give you the best care, learn as much as you are able to 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.
  - o Make sure your doctors know all of the drugs you are taking, including over-the- counter drugs, vitamins, and supplements.
  - o 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 don't understand the answer you are given, ask again.
  - o 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.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - o In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - o For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Your EOC Chapter 4 tells you what you must pay for your medical services. EOC Chapter 6 tells you what you must pay for your Part D prescription drugs.

- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. See your EOC Chapter 9 for information about how to make an appeal.
    - o If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - o If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services at the number listed above.

o **If you move *outside* of our plan service area, you cannot remain a member of our plan.** Your EOC Chapter 1 tells 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 Medicare plan available in your new area. We can let you know if we have a plan in your new area.

o 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.

o If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in your EOC Chapter 2.

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

    - Phone numbers and calling hours for Member Services are listed above.
    - For more information on how to reach us, including our mailing address, please see your EOC Chapter 2.

SECTION 19. 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 California, Inc./Imperial Insurance Companies, Inc. (Imperial) is complying with all applicable rules and regulations governing the administration of Exchange and Medicare Advantage 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.

      Medicare only:
        - Within 60 days after the date of denial/Notice of Action letter
        - Non-Contract Provider (NCP) appeals will require a signed and dated Waiver of Liability (WOL) unique to the appeal. The WOL must be received within the 60 day timeframe and the processing timeframe will not start until the WOL is received.
    - Appeal maybe be written or verbal
    - Imperial does not accept appeals via Provider or Member portal at this time
    - This applies to appeal decisions related to coverage or rescission of coverage, whether or not the denial resulted from medical necessity review. A member may appeal against any adverse medical necessity or benefit decision.
    - Interpretation services will be available for accepting verbal Appeals
    - Appeals will be accepted by any department or first-tier, downstream or related entity and immediately forwarded to the Appeals & Appeals department (A & G) for investigation and resolution.
    - Upon receipt an acknowledgement letter will be sent, by A & G, to the appellant within 5 businesses days of receipt. Urgent cases will also be responded to via phone call to the appellant.
    - Processing timeframe will begin when the plan, any unit in the plan, or a delegated entity (including those not responsible for processing the request) receives a request.

      Medicare only:
        - The processing timeframe begins when the A & G department receives the request.

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

Medicare only: .
- If a physician (Part C)/prescribing physician or other prescriber (Part D) makes a request or supports an enrollee's request for an expedited appeal and indicates that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words), the plan must process as expedited.

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
- IRE (Medicare) or IRO (Exchange) documentation including:
    - Case files submitted to the IRE or IRO
    - Decisions from IRE or IRO
    - Appellant notification of IRE or IRO decisions
    - Proof of effectuation when necessary

- Any documentation Imperial feels is relevant to the case

Exchange only:

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

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

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

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

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

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

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

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

  Pharmacists:
  - Pharmaceutical denials.

  Dentists:
  - Dental denials.

  Chiropractors:
  - Chiropractic denials.

  Physical therapists:
  - Physical therapy denials.

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

Medicare only:
- Part B Drug and Part D standard Pre-Service or Benefit appeals will be responded to within 7 days
- expedited Part B Drug appeals will be responded to within 72 hours
- Part D payment appeals will be responded to within 14 days
- Imperial may take a 14 day extension if the member requests the extension, or the plan justifies a need for additional information and documents that the delay is in the member's best interest. Imperial will provide a written extension notice to the member if an extension will be taken, along with a reason for the delay.

- Part B Drug appeals cannot be extended
- Imperial will allow Members to request an extension of the processing timeframe
- Prior to closure
    - All cases will be reviewed by A & G Supervisor for completeness and accuracy
    - All documentation will be attached to the case, either in folder or system.

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)
   - This does not apply to Medicare Part D
       - Additional appeal rights including description, procedures and time frames, if appropriate

     Medicare only:
       - If themember'srepresentativesubmitsarequest,therepresentativewillbe notified in lieu of the enrollee.

     Exchange only:
       - 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 IRE or IRO

Medicare only:

- Imperial will send any upheld Part C denials to Maximus for review
- Imperial will follow CMS and Maximus protocol for submission of the case
- Imperial will send any untimely Part D cased to C2C for review

- 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 IRE
    -

Exchange only:

- 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 IRE& IRO
    - Imperial will follow CMS and Maximus, C2Cor the IRO protocol for effectuation

8. Medicare only: Withdrawn Appeals

- An appellant member may submit an oral or written withdrawal request for an appeal any time before the decision is mailed by Imperial
- Imperial will clearly document in the system that the appellant does not want to proceed with the appeal
- Imperial will send a written confirmation of that withdrawal to the appellant within 3 calendar days of receiving the withdrawal request

9. Medicare only: Dismissed Appeals

- Imperial will dismiss an appeal in the following circumstances:
    - An individual requests a reconsideration on behalf of a member, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the member’s behalf. This does not relieve Imperial of its obligation to make attempts to secure the missing documentation.
    - The member or other party fails to file the appeal within the established timeframes and good cause for late filing has not been established.

- A non-contract provider requests an appeal but fails to provide a Waiver of Liability statement indicating that the non-contract provider will not bill the member regardless of the outcome of the appeal. Prior to dismissal, Imperial will make attempts to secure the missing documentation.
- Imperial becomes aware that the member has obtained the service before the plan completes its pre-service reconsideration.
- Any other circumstance where Imperial does not have jurisdiction to review the case.

- 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

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

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

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- 20

FORMS, APPENDICES, POLICIES & PROCEDURES

Case Management Referral Form

Case Management Referral Form 2025.p

UM- Policy & Procedure

UM- Policy & Procedure.pdf

UM- Prior Auth. P&P

UM- Prior Auth. P&P.pdf

Appeals P&P

P&P for Appeals.pdf

Compliance Program Description

Compliance Program Description

Policies & Procedures

Policy and Procedures 2025.pd

Policy & Procedure Attachments

Policy and Procedure Attachment

Compliance Training & Education

2025 Compliance Training and Education

EZ-Net Provider Portal Guide

EZ-Net Portal Guide.pdf

EZ-Net Provider Portal Access

EZ-Net Portal Guide Portal Access Reque

Compliance Training Quiz

2025 Compliance Training Quiz.docx

Compliance Training Attestation

2025 Compliance Training Attestation

Code of Conduct

Code of Conduct 12.19.24.pdf

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

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

Case Management Referral Form

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

Referring Provider: | **Email:**

Member name:	Date of Birth:

Member address:	Member phone number:

Type of Case Management services needed: (check one)

☐	Case Management

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

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

Primary diagnosis:

Additional information:

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department

Policy Title: UM Medical Necessity Criteria - Use of Hierarchy	
Policy Number(s): UM-518	**Orig. Date:** 05/01/16
Effective date: Orig. Date: 06/27/24	**Revision Dates:** 06/27/24, 11/06/24
MSC Committee Approval: **Date:11/06/24**	**Department: Utilization Management**
	VP/Director Approval: Date:
Applicable to: ☒**IHP** ☒**IHHMG** ☒**IICT** ☒**HCMG**	**SCOPE: UM**

SCOPE
Imperial Health Plan, Imperial Health Holdings Medical Group, Imperial Insurance Companies, HealthCosmos Medical Group, shall follow the procedures set forth in this policy.

PURPOSE & POLICY
The purpose of this policy is to ensure efficient and effective processing of requests for items and services, utilizing a specific hierarchy of references to guide decision-making.

PROCEDURE:

The Chief Health Officer has oversight of any UM physician reviewer(s) making medical decisions.

CLINICAL CRITERIA FOR UM DECISIONS

- Evidence based; nationally accepted criteria are utilized when authorizing services. In addition, the members' needs: age, co-morbidity, complications, home environment, treatment progress and psychosocial situation are also taken into consideration.
- Application of the criteria shall be based on the needs of individual patients and characteristics of the local delivery system.
- Criteria are objective and based on medical evidence and are consistent with National Coverage Determinations (NCD Local Coverage Determinations –(LCD, Health Plan coverage guidelines. / Medical Policy, and Nationally accepted, evidenced based criteria, such as MCG.
  - Criteria utilized in decision making are made available to providers and members upon request.
  - Criteria are objective and based on medical evidence and are consistent with

The Hierarchy Criteria Order of Use is as follows: Medicare Advantage Membership

- CMS National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- Local Coverage Articles (LCA) (Active/Retired)
- Medicare Claims Processing Manual
- Medicare Benefit Policy Manual
- Medicare Managed Care Manual
- Health Plan Criteria / Medical Policy
- MCG Health 27th Edition
- Specialty website (NCCN)

The Hierarchy Criteria Order of Use Is as Follows: Medi-Cal membership

- MMCD California Policy Letters
- DHCS Coverage and Benefit guidelines
- Health Plan Criteria / Medical Policy
- MCG Health 27th Edition
- Specialty website (NCCN)

The Hierarchy Criteria Order of Use Is as Follows: Commercial

- Health plan criteria or policy
- MCG Health 27th Edition
- Specialty website (NCCN)
- National Center of Complementary Integrated Health (NCCIH)
- UpToDate

For MMP and other integrated Dual Medicare/Medicaid member requests: If the service is not approvable under Medicare Coverage, the request must be reviewed under the applicable Medicaid hierarchy, including state-specific Medicaid guidelines for medical necessity criteria.

APPLICATION OF CRITERIA

- Application of the criteria will depend upon the member's age, co-morbidities, and progress in treatment, psychosocial situation, home environment, network resources and support system. The decision-making for UM is based only on appropriateness of care and service and existence of coverage.

- Assessment of staff and physician reviewer performance in the application of the criteria shall be performed and evaluated through the use of the Inter-Rater Reviewer Reliability Survey of each UM Staff member and physician reviewer.

- Access to complete criteria can be obtained by practitioners or members by contacting the Chief Health Officer or the UM Department, by telephone or fax

REFERENCE:

CMS
DHCS
MCG
Medicare Managed Care Manual (MMCM) Chapter 4
Medicare Claims Processing Manual (MCPM) (Publication 100-04)
Medicare Benefit Policy Manual (PBPM) Chapter 15, 42 CFR 422.101

ATTACHMENT

None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure

Utilization Management Department

Policy Title: Prior Authorization Process	
Policy Number(s): UM-101	**Orig. Date:** 05/01/16
Effective: 10/07/22	**Revision(s) Date:** 06/25/17, 09/01/19, 11/15/20, 12/01/20, 07/19/21, 11/10/21, 02/01/22, 10/07/22, 03/28/24,07/31/24, 11/06/24
MSC Committee Approval Date: 11/06/24	**Department:** UTILIZATION MANAGEMENT
	VP/Director Approval: **Date:**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT ☒ HCMG ☒ LSMG	**SCOPE: UM**

SCOPE
Imperial Health Plan, Imperial Insurance Companies, Imperial Health Holdings Medical Group, HealthCosmos Medical Group, and LoneStar Medical Group shall follow the procedures set forth in this policy.

PURPOSE
To establish a standardized process for managing prior authorization requests within the utilization management framework, ensuring timely decisions while optimizing patient care and resource utilization.

POLICY
The organization will ensure efficient and effective processing of prior authorization requests, adhering to established timelines for determination,

Providers shall obtain authorization for all services that are NOT listed on the ***Direct Referral Form*** **(**Attachment A) prior to delivering those services.

The Utilization Management (UM) Department has the capability to receive the request via fax, written requests, provider portal, or orally for both standard and expedited preservice determinations and can accept requests from members or providers.

All requests, including oral transcription, are documented and maintained in case specific files within the prior authorization application.

Providers shall determine member eligibility, benefit coverage, medical appropriateness, necessity and level of care prior to submitting the request. Providers shall be notified in writing, at time of contracting, of the services that require prior authorization and shall be provided with all relevant forms. Any updates to the *Direct Referral Form* shall be communicated in writing to all

contracted providers and affected departments at least 30 days prior to any changes.

PROCEDURE

1. The Prior Authorization Utilization Management Coordinator (UMC) receives standard and expedited requests for prospective, concurrent, and retrospective services through the following channels:
   1.1. Physicians, both contracted and non-contracted, submit requests through the fax, hard copy, provider portal, or orally.
   1.2. Physicians submit hard copy requests on a standardized prior authorization request form.
   1.3. Physicians or members may request a service orally.
   1.4. Members and their authorized representatives may also request prior authorization for services.
2. Each request is date and time stamped when received.
3. The requesting Physician submits timely prior authorization requests with the required information for processing, such as member information and medical necessity documentation. The physician indicates whether the request is standard or expedited based on the urgency of the service.
4. The UMC receives the prior authorization request and verifies eligibility, benefits, and required information for processing. This includes the member name, address and telephone number, member ID number, diagnosis codes (ICD-9/10) for all applicable diagnoses, requested service codes (CPT) for all applicable services, requested provider, Primary Care Physician or Specialist name and his/her Tax Identification Number (TIN), telephone and fax numbers and clinical support information to use in application of criteria.
   4.1. If the member is not eligible, the UMC contacts the referring provider and directs them to contact the member for clarification of coverage / assigned PCP.
   4.2. If the member does not have the benefit, the UMC forwards it to the RN / LVN (Nurse) who will discuss with the Medical Director and generate a Benefit Denial Letter.
5. The UMC data enters Fax and oral Requests into the prior authorization application. S/he checks the prior authorization request for receipt of all necessary information. If clinical information is incomplete, outreach is performed and the referring source is contacted for the missing required information. A minimum of 3 attempts are made to collect necessary information.
6. The UMC gathers relevant clinical information to support nonbehavioral healthcare UM decision making. Requests for Behavioral Health are directed to the carved out Behavioral Health Organization.
   6.1. The organization, when conducting routine prior authorization review, concurrent review, or retrospective review will:
      6.1.1. Accept information from any reasonably reliable source that will assist in the authorization process
      6.1.2. Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services
      6.1.3. Not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for authorization, but may request such codes, if available
      6.1.4. Not routinely request copies of all medical records on all patients reviewed
      6.1.5. Require only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work
      6.1.6. Administer a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from members or providers.
7. If the clinical information can be obtained over the telephone, the UMC transfers the call to a

Nurse to take a telephone order and document the information online with his/her initials as a valid signature. The Nurse must indicate to the requesting physician, at the time of the call, that s/he is responsible for sending in the supporting documentation the same day.

8. If the plan does not receive any additional information, the plan will make the best decision it can based on the information available within the required adjudication timeframes. Any adverse determination is to be made by a Physician.

Methods for requesting information should vary depending on the type of request and the adjudication timeframe. Outreach methods can include:

- Telephone;
- Fax;
- E-mail; and/or
- Standard or overnight mail with certified return receipt.
- For Commercial urgent concurrent decisions, voicemails are not an acceptable form of oral notification.

Best Practice for Medicare Advantage Organizations for Outreach

	Adjudication Timeframe	Number of Outreach Attempts	Timing of Outreach Attempts
Standard Org Determination- Pre-Service	14 days	3	*Initial attempt within 2 calendar days of request *When possible, during business hours in the providers time zone
Expedited Org Determinations	72 hours	3	*Initial attempt upon receipt of request, must request within 24 hours of receipt *When possible, during business hours in providers time zone

Processing Turnaround Times

See appendices for timeliness standards.

Processing requests

9. The UMC forwards the request to the Nurse's queue no later than one working day of receipt, or as expeditiously as the member's health requires.
10. The Nurse reviews the prior authorization requests in the order received except for expedited requests which are given priority and reviewed the same date of receipt.
11. The UM Manager reviews pended cases throughout the day and at the close of business. S/he will reprioritize the Nurse's case load as necessary.
12. The organization ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity (i.e., not routinely conducted on a daily basis).
13. For prior authorization and concurrent review, Imperial bases review determinations solely on the medical information obtained by the organization at the time of the review determination.

14. For ongoing care, reductions or terminations in a previously approved course of treatment, the organization issues the determination early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs.
15. If the referral request lacks the information necessary to establish medical necessity, the Nurse faxes a request for more information to the referring source specifying the information needed and documents actions in the UM system.
    15.1. Clinical information to be obtained must include at a minimum
        15.1.1. History of presenting problem, clinical exam
            15.1.1.1. Findings, diagnostic testing results, treatment progress notes, psychosocial history, information on
            15.1.1.2. Consultations with the treating practitioner, evaluations from other health care practitioners and providers, photographs, operative and pathological reports, rehab evaluations, printed copy of criteria related to the request, information regarding benefits for services or procedures,
            15.1.1.3. Information regarding the local delivery system, info from patient and responsible family members.
16. If the referring source classified the referral as expedited and the Medical Director needs additional information in order to establish medical necessity for expediting the case, the Nurse will automatically downgrade the request to standard processing time, and verbally notify the member. Written notification to both the member and the provider will be provided within 24 hours., The written notification informs the member of his/her right to file an expedited grievance if he/she disagrees with the decision.
17. If the case is a request for medication, thus not qualifying for downgrade, the Nurse shall submit the case to the Medical Director for a determination.
18. The member will be notified of the decision via the specific CMS approved Health Plan Templates.
19. The notification informs the member of his/her right to file an expedited grievance if s/he disagrees with the decision not to expedite. The Medical Director and Nurse document their actions related to the decision in the UM system.
20. If the referring source classified the referral as standard and the Medical Director needs additional information in order to establish medical necessity, the Nurse will request additional information. If the information is not received within a reasonable timeframe to allow for a timely decision, the case will be referred to the reviewing physician for an initial determination.

    Extension of the determination timeline is allowed if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member. (For example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). If extension is determined to be in the best interest of the member, the plan's existing extension policy will be observed.
21. .
22. The Medical Director reviews any incomplete request and determines whether to approve as requested, pend for lack of information or documentation, or deny for medical necessity.
23. If Imperial cannot make a determination for non-urgent prospective or continued stay reviews within the required time frame due to not received all of the requested necessary information, Imperial will Immediately notify the health care provider and the covered person in writing
    23.1. Send notification upon the expiration of the required give (5) business day time frame OR as soon as Imperial becomes aware that they will not be able to meet the required five (5) business day time frame, whichever occurs first, the anticipated date on which a prospective or continued stay review determination may be rendered
        23.1.1.1. Notification will specify the information required, but not received
24. Upon receipt of all necessary information, Imperial will render a prospective or continued stay review determination within the required five (5) business day time frames
25. If a contracted physician continually fails to provide complete member information or necessary

documentation in order to establish medical necessity, the Nurse refers the issue to the Provider Services/Contracting Director so that further provider education can take place.

26. The Nurse reviews the request, applies criteria, and documents prior authorization requests.
    - 26.1. Determinations will result in one of the following:
        - 26.1.1. Approve request if it meets criteria or
        - 26.1.2. Submit the request to the Medical Director when criteria are not met
        - 26.1.3. The Medical Director reviews request when requested services do not meet established medical necessity, or benefit coverage guidelines, or are considered experimental or investigational or the request if out-of-network
            - 26.1.3.1. If the request is experimental or investigational, including clinical trials, it will be immediately referred to the health plan for initial determination, regardless of benefit exclusion
        - 26.1.4. The Medical Director may confer with Board Certified Specialty Consultants in the related specialty and discuss the case with the requesting physician before making the determination. Determinations results in one of the following:
            - 26.1.4.1. Approve, as requested;
            - 26.1.4.2. Deny for lack of medical necessity; or
            - 26.1.4.3. Deny as modified, if only a portion of the request was approved
            - 26.1.4.4. Deny because the service is not a covered benefit
    - 26.2. The Medical Director documents his/her decision in the UM system and submits the case to the Nurse to make changes to the status field to approve or deny based upon his / her direction.
        - 26.2.1. In cases where a favorable determination takes place for any of the following procedures, the Nurse or assigned staff first confirms that the facility that is being authorized is a Medicare Certified facility to perform the specified procedure. This can be validated at the CMS website: www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp
        - 26.2.1.1. Carotid artery stenting
        - 26.2.1.2. Certain oncologic PET scans in Medicare-specified studies
        - 26.2.1.3. Lung-volume reduction surgery
        - 26.2.1.4. Ventricular assist device (VAD) destination therapy

29. During the course of reviewing the case, the Medical Director, the Nurse, or the UMC may make a recommendation for the referral of member to appropriate service including case management of pregnant member, member in need of behavioral health services, care coordination case management, disease management, or refer members with high ER utilization for case management.
    - 29.1. Some services may be immediately referred, others may require coordinating with the Primary Care Provider,

DEFERRED Process/Procedure (Only for Commercial\Medical LOB)

If a decision will be deferred for lack of clinical information needed to make a determination, a **Deferral Letter** is to be sent out within regulatory timeline for respective line of business -Refer to Pended Referral/Authorizations-Extension Policy for more information

Dismissal or Withdrawal

A request for an initial determination be withdrawn at any time before the decision is issued. This request must come from the party who requested the initial determination. The request to withdraw may be either written or verbal. A provider may cancel or withdraw a referral request in writing or by telephone stating the reason for the cancellation request. If a request to withdraw is filed with the

plan, the plan will dismiss the initial determination request. For detailed information on Dismissal or Withdrawal Procedures, see policy Dismissals and Withdrawals of an Initial Determination Request .

Termination, Suspensions, or Reductions For Medi-Cal Health Plans Only

For terminations, suspensions, or reductions of previously authorized services, MCPs must notify members at least ten days prior to the date of the action pursuant to Title 42 CFR section 431.211 to ensure there is adequate time for members to timely file for Aid Paid Pending, with the exception of circumstances permitted under Title 42 CFR sections 431.213 and 431.214.

Standing Specialist Referrals Including HIV/AIDs

1. A member, who requires specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), may be allowed a standing referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the members healthcare.
2. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, the Provider Organization will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria.
3. The PCP, specialist and designated physician determines that continuing care from a specialist is needed and referrals are made based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized, and may require the specialist to make regular reports to the PCP.
4. After receiving standing referral approval, the specialist is authorized to provide healthcare services that are within the specialists area of expertise and training to the member in the same manner as the PCP.
5. Decisions will be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 business days of the date that all necessary information is received.
6. If authorized, the actual referral (notification) will be made within 4 business days of the date and the proposed treatment plan, if any, is submitted to the designated physician (e.g., Medical Director).
7. If a network specialty provider is not available to see the member within the access timeframes, there is a process for arranging specialty care outside of the network.
    - 7.1. The UM Nurse discusses the case with the Medical Director and reaches out to a non-contracted provider to make the referral. The non-contracted provider shall be within the same geographic area.
    - 7.2. The UM Nurse will ask the provider if s/he will accept Medicare / Medi-Cal FFS rates. If s/he agrees, the Nurse shall contact Provider Contacting to obtain a Letter of Agreement
    - 7.3. In cases where an Adverse Determination takes place refer to the Adverse Determinations Policy & Procedure

Prior-Authorization processing is tracked through the online reports:

- Authorization turnaround times;
- Percentage authorization category;
- Favorable Determinations

- Adverse Determinations
- Extensions
- Appeals
- Nurse productivity
- UMC productivity
- Unused/Expired Authorization (MCL)

The Manager of UM monitors' online system reports in order to ensure compliance with timeframes – See Appendix

If procedures are not adhered to, the Manager of UM develops a corrective action plan as necessary in order to ensure compliance with policies and procedures.

Medi-Cal Member Transition from FFS to Medical Managed Care Plan (MMCP)

Members that transition into a MMCP, have the right to request Out of Network (OON) and Continuity of Care (COC) in accordance with State law and health plan requirements.

The Programs include:

- Low Income Health Program (LIHP)
- Medical Exemption Request (MER)
- Seniors & Persons with Disabilities (SPD)
- Other Targeted Low Income Children (OTLIC) Continued access is permitted for care for up to 12 months
-

OON and COC requests are processed within five (5) working days of receipt of request and must be completed within thirty (30) calendar days. When the medical condition requires more immediate attention, the organization follows ICE Medi-Cal TAT Standards.

Submission of quarterly reports to the health plan are required based upon contractual terms.

Beneficiary protections related to plan-directed care, CMS chapter 4 section- 160:

A member, or a provider acting on behalf of the member, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies an enrollee's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the enrollee (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS- 10003).

Electronic Communication of Required Materials
With prior authorization from the enrollee, the Part D sponsor may provide required materials or content electronically. To ensure compliance with 42 CFR 422.2267 and 423.2267, the following procedures must be followed:
Obtain Prior Consent:
The sponsor must obtain prior consent from the enrollee.
The consent must specify both the type of media (e.g., email, online portal) and the specific materials being provided in that media type.
Access Instructions:
The sponsor must provide clear instructions on how and when enrollees can access the materials electronically.

Hard Copy Requests:
A process must be in place for enrollees to request hard copies of materials, either as a one-time request or as a permanent request.
Permanent requests must remain in place until the enrollee chooses to receive electronic materials again.
Hard copies must be mailed within three business days of the request.
Undeliverable Electronic Materials:
If electronic versions or the chosen media type are undeliverable, there must be a process for automatically mailing hard copies of the materials to the enrollee.

Reference(s)
42 CFR422.204(b)(1) and (3);
42 CFR §§ 431.211, 431.213 and 431.214
42 CFR §§ 422.566, 422.568, 422.570, 422.572
42 CFR 422.2267 and 423.2267
MA-14 Element F
NCQA UM 1, NCQA UM 6 QA UM 13 A QI 7, QI 8)
CMS MANUAL CHAPTER 4 SECTION 150, 160
State Contract; standards used based on state contract if more stringent
29 CFR 2560.503-1(b)(1)(f)(2)(i); 29 CFR 2560.503-1(b)(1)(f)(2)(iii)(A);
CA Health & Safety Code 1367.01 (h)(5)

Appendices

Utilization Management Timeliness Standards, (Medi-Cal Managed Care - California)

Utilization Management Timeliness Standards, Centers for Medicare and Medicaid Services (CMS)

Utilization Management Timeliness Standards, (Commercial HMO - California)

Attachment(s) ATT A – Medi-Cal TAT ATT B –

Commercial TAT

Direct Referring Services Form

Direct Access Referral form (Auto

Request for Clinical Information Fax Cover Sheet

Need Clinical Info Fax Cover Sheet.docx

Best Practices for Conducting Outreach for Medicare Advantage Organizations

Outreach.docx

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification** **(Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service **– Extension Needed** • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or		

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	tests required and the anticipated date on which a decision will be rendered **Additional information received** • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service **Additional information incomplete or not received** • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial	Practitioner: Within 24 hours of making the decision Member: None Specified Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group / Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information	Within 72 hours of receipt of the request	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
			Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When 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, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination **CA H&SC 1367.01 (h)(2)**	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may chose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request **Note:** If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request
Post-Service - Extension Needed Additional clinical information required	**Additional clinical information required (AKA: deferral)** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request		
	Additional information received • If requested information is received, decision must be made within 30 calendar days of receipt of information • Example: Total of X + 30 where X = number of days it takes to receive requested information	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination
	Additional information incomplete or not received • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information	Member & Practitioner: None Required	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. ***Extension Notice:*** ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination;

Type of Request	Decision	Notification Timeframes
	▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **Approvals** – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.
Expedited Initial Organization Determination **- If Extension Requested or Needed**	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. Extension Notice:

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Type of Request	Decision	Notification Timeframes
	additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Give notice in writing, within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Approvals – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
	physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)**	The Health Plan or delegate is responsible for making the decision to end services no later than two	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized

▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	(2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.
Part B and C Prescription Drugs	▪ **Standard:** Within 72 hours of receipt of request ▪ **Expedited:** Within 24 hours of receipt of request	▪ **Standard:** Within 72 hours of receipt of request ▪ **Expedited:** Within 24 hours of receipt of request	**Standard:** Within 72 hours after receipt of request. • Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision • Part B drugs cannot be extended **Expedited:** **<u>Approvals</u>** ▪ Oral or written notice must be given to member and provider within 24 hours of receipt of request. ▪ Document date and time oral notice is given. ▪ If written notice only is given, it must be received by member and provider within3 calendar days of receipt of request. **<u>Denials</u>** ▪ Oral or written notice must be given to

			member and provider within 24 hours of receipt of request. ▪ When oral notice is given, it must occur within 24 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. ▪ Document date and time of oral notice. ▪ If only written notice is given, it must be received by member and provider within 24 hours of receipt of request. ▪ Use NDMC template for written notification of a denial decision.
Part D Prescription Drugs (only)	▪ **Within 24 hours of receipt of request**	▪ Within 24 hours of receipt of request	**For Approvals or Denials**: Within 24 hours after receipt of request. • Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision **<u>Approvals or Denials</u>** ▪ Oral or written notice must be given to member and provider within 24 hours of receipt of request. ▪ When oral notice is given, it must occur within 24 hours of receipt of request and must be followed by written notice to the member within 3 calendar days of the oral notice. ▪ Document date and time oral notice is given. ▪ If written notice only is given, it must be received by member and provider within 24

			hours of receipt of request. **Denials** ▪ When oral notice is given, it must occur within 24 hours of receipt of request and must be followed by written notice to the member within 3 calendar days of the oral notice. ▪ Document date and time of oral notice. ▪ If only written notice is given, it must be received by member and provider within 24 hours of receipt of request. ▪ Use NDMC template for written notification of a denial decision.

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. **Note:** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
	<u>Additional information not received:</u> If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. **Note:** Decision must be made in a timely fashion appropriate for the member's condition <u>not to exceed 48 hours after the deadline for extension has ended.</u>	*<u>Additional information not received</u>* <u>Practitioner:</u> Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). <u>Member:</u> Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*<u>Additional information not received</u>* Within 48 hours after the timeframe given to the practitioner & member to supply the information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to <u>*Urgent Pre-service*</u> category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to <u>*Non – urgent Pre-service*</u> category.	Within 24 hours of receipt of the request.	<u>Practitioner:</u> Within 24 hours of receipt of the request (for approvals and denials). <u>Member:</u> Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes &** **Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals** **(Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Standing Referrals to Specialists / Specialty Care Centers **-** All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	<u>Practitioner and Member:</u> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	<u>Practitioner and Member:</u> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	<u>Practitioner:</u> Within 24 hours of the decision (for approvals and denials). <u>Member:</u> Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	<u>Additional information received or incomplete:</u> If additional information <u>is received</u>, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	<u>Practitioner:</u> Within 24 hours of the decision (for approvals and denials). <u>Member:</u> Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes &** **Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals** **(Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
	<u>Additional information not received</u> If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	<u>Require consultation by an Expert Reviewer:</u> Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*<u>Require consultation by an Expert Reviewer</u>***:** <u>Practitioner:</u> Within 24 hours of the decision (for approvals and denials). <u>Member:</u> Within 2 business days of the decision (for approval decisions).	*<u>Require consultation by an Expert Reviewer:</u>* Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
	<u>Additional information not received</u> If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*<u>Additional information not received</u>* <u>Practitioner:</u> Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). <u>Member:</u> Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*<u>Additional information not received</u>* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	*LAP Services Not Delegated:* All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		*LAP Services Delegated/Health Plan:* All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

Imperial Health Plan of California .

Member Satisfaction Survey

1. How long did you wait to get an appointment

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

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

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

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

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

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

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

8. How long did you wait to get an answer on your referrals from Imperial Health Plan of Ca?

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

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

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

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

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

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

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

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

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

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

†Yes †No

Additional comments: _____

Your primary care physician's name: _____

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

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

2024 PROVIDER SATISFACTION SURVEY

Please take a few minutes to fill out this survey on the timeliness and quality of the service you receive from Imperial Health Plan of California and FAX it back to 626-283-5022. Thank you for your participation.

ADMINISTRATIVE SECTION

Provider Network Operations

1. I have been supplied with:

A Provider orientation **YES ☐** **NO ☐**
Access to the Web Portal **YES ☐** **NO ☐**

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

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

Claims

4. My claims are processed in a timely manner
Strongly Agree ☐ **Agree ☐** **Disagree ☐ Strongly Disagree ☐**
Claims inquiries are answered promptly

5. Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

6. Are you aware Imperial Health Plan 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 IHPCA are accurate

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

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

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Utilization Management

10. UM Representatives are helpful

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

11. Referrals are processed in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

12. Denial notifications consistently provided denial reasons

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Credentialing

13. The Credentialing process occurred in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

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

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

15. Credentialing Coordinator is courteous and knowledgeable

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Please provide additional comments or suggestions:

_____

_____

_____

_____

_____

_____

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

Revised:July 2022

IMPERIAL HEALTH PLAN OF CALIFORNIA

PO Box 60874

Pasadena, CA 91116

KEY CONTACT LIST

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

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

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

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

IMP RIAL
HEALTH PLAN
OF CALIFORtIIA

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

Pre-Certification Referral Form

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

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

CMS Defines an expedited request as a request in which waitingfor a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

A. MEMBER INFORMATION:

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

B. ICD-10-CM DIAGNOSIS CODE:

CODE DESCRIPTION

Primary
Secondary
Other
Other

C. CPTIHCPCS CODE:

CODE DESCRIPTION QUNTS

1)
2)
3)
4)

D. REFERRED TO PHYSICIAN /ANCILLARY/ FACILITY:

REFERRAL PRIORITY: STANDARD URGENT

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

Referred to Physician	Provider/ NPI ID #	Phone Number	Fax Number
Referred to Physician Address		Name and Direct Contact # completing this form	
Referred to Ancillary/Facility	Facility / NPI ID #	Phone Number	Fax Number
Referred to Facility Address		Office Ambulatory Surgical Center	Outpatient Hospital

E. SERVICE INFORMATION:

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

OHomeO DME 01npatient/Acute **D**Rehab/LTAC **DNF**

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

Requested Date of

Service Scheduled

Admit Date

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

IMPERIAL HEALTH OLD[NGS
MEDICAL GROUP

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

Pre-Certification Referral Form

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

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

CMS Defines an expedited request as a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum junction in serious jeopardy.

A. MEMBER INFORMATION:

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

B. ICD-10-CM DIAGNOSIS CODE:

CODE DESCRIPTION

Primary _____
Secondary _____
Other _____
Other _____

C. CPT/HCPCS CODE:

CODE DESCRIPTION QTY UNITS

1) _____
2) _____
3) _____
4) _____

D. REFERRED TO PHYSICIAN/ ANCILLARY/ FACILITY:

REFERRAL PRIORITY: ☐ STANDARD URGENT

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

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

E. SERVICE INFORMATION:

D Office D Ambulatory Surgical Center D Outpatient Hospital Requested Dale of Service

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

Scheduled Admit Dale

OHomeO DME 01npalienl/Acute **D** Rehab/LTAC **DNF**

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

Policies and Procedures

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure

Subject: Credentialing Program	**Policy Manual:** Imperial Management Administrators Services (IMAS)
Effective Date: May 1, 2016	**Policy Number(s):** 05-01-16-02-001
Reviewed Dates: N/A	
Revision Dates: 5/17/2017, 11/28/2018, 7/24/2019, 5/27/2020, 9/21/20, 3/31/21, 4/1/2021, 5/28/2021, 6/9/2021, 11/19/2021, 8/11/2023, 10/3/2023, 3/15/2024, 4/12/2024	**Department: CREDENTIALING**
	Title: Credentialing Manager
Last Revised by: Denise McMillian	**Approval Signature:** On File

SCOPE

Imperial Management Administrators Services (IMAS) herein and throughout the policies shall cover the following entities:

- IMAS
- Imperial Health Holdings Medical Group
- Imperial Insurance Companies
- Imperial Health Plan of California
- HealthCosmos Medical Group – Arizona
- HealthCosmos Medical Group – Nevada
- Lone Star Medical Group

PURPOSE

The purpose of the Credentialing Program is to provide the framework to ensure that healthcare practitioners meet minimum credentials and performance standards. Implementing credentialing and recredentialing processes is vital to the integrity of the network providing quality health care and services to patients.

Credentialing is completed for practitioner applicants in conjunction with contracting.

POLICY

Authority

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Subject: Medi-Cal Provider Dispute Resolution	**Policy Manual:** Imperial Health Holdings Medical Group
Effective Date: May 1, 2016	**Policy Number(s):** 05-01-16-07-0017
Reviewed Dates: N/A	
Revision Dates: 04/14/2024	**Department: CLAIMS**
	Title: President/Chief Medical Officer/Medical Director
Last Revised by: N/A	**Approval Signature:** On File

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

This policy applies to the Medi-Cal line of business.

PURPOSE

To set forth the policy and procedure for processing all provider claims disputes.

POLICY

It is the policy of Imperial Health Holdings Medical Group to adhere to requirements specified in Sections 1300.71 and 1300.71.38, California Code of Regulations Title 28, Claims Settlement Practices and Dispute Resolution Mechanism, when processing provider claims disputes. Imperial Health Holdings Medical Group shall not impose a deadline for the receipt of a dispute that is less than 365 days from the last date of action.

PROCEDURE

1. Types of Provider Dispute Resolution (PDR) issues. Provider disputes that are submitted to Imperial Health Holdings Medical Group may contain requests to review the following types of issues:

    a. Claim payment or denial. Provider disputes payment or denial of claim for any reasons including timely submission, request for retroactive authorizations, eligibility, etc., are tracked through the PDR Database within the Claims Department.

b. Disagreement with request for overpayment. Provider disputes a request for reimbursement of an overpayment of a claim. The dispute is logged in the PDR database and acknowledged. The dispute is routed to Claims Revenue Recovery for research. Once it is finalized, it is returned to the Claims Specialist for the resolution letter.

c. Contract/DOFR interpretation disputes. When a provider dispute arises from a difference in understanding of a contractual interpretation, fee schedule or any term and condition of the contract, the dispute is reviewed and researched by the Claims Department and when research complete resolution letter is issued.

d. Denial of authorization for "pre-service" requests. When a pre-service dispute is received within the Claims Department, it is directed to the Network UM Department for review and retro-authorization determination. Once claim is received back from UM Department the Claims department issues a resolution letter.

2. Required submission of information. The provider must utilize the PDR Request Form a written notice that contains, at a minimum, the following information:
    a. Provider's name;
    b. Provider's identification number;
    c. Contract information; and
    d. A clear explanation of the disputed item, the date of service and a clear identification of the basis upon which the provider believes the payment amount, request for additional information, and request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

3. Receipt of claims. The Claims Mailroom Unit receives all Claims Department mail and is responsible for the sorting, batching, date stamping and inventory of all claim receipts.
4. Provider dispute must be acknowledged within 2 working days if submitted electronically or 15 working days if submitted in paper
5. IHHMG shall not impose a submission deadline of less than 365 days from action or in case of inaction, no less than 365 days after the time for contesting or denying a claim has expired
6. Resolution of Provider Dispute must be made in writing within 45 working days from the receipt of dispute
7. Whenever a payer contests, adjusts or denies a claim it shall inform the provider of the ability to dispute and include the procedure for obtaining forms, along with mailing address for submission of disputes

Initial Review

1. For paper claim disputes, the Claims department makes the initial determination of provider dispute(s) and sends acknowledgement letter(s) within fifteen (15) working days from date received. For electronic claim disputes an acknowledgement letter is sent within two (2) working days from date received.

2. If the Claims department determines that the submitted information is not a PDR, the information is forwarded to Claims Mailroom Unit for batching to Claims Examiners.

3. The Claims department enters the disputed information into the Imperial Health Holdings Medical Group Provider Web Portal. Information from Imperial Health Holdings Medical Group portal is automatically transferred to PDR Database.

4. The database automatically generates an acknowledgement letter based on the data entered above. Once this letter is issued, the data cannot be altered. Acknowledgment letters are sent the same day they are generated.
5. The Claims Specialist prints a tracking form that is generated by the database for each PDR submission. The tracking number is noted in the claims system history for cross-reference.

6. The Claim Specialist batches the PDRs by received date and enters received date and claims count into Inventory Control Database for inventory tracking.

Final Determination

7. The Claims department reviews PDRs based on oldest date on hand.

8. The Claims department reviews the details submitted by the provider to determine if Imperial Health Holdings Medical Group initial, decision should be overturned or upheld.

9. If a dispute is in favor of the provider, payment is issued to the provider within five (5) working days of determination. All applicable interest owed is included in the payment.

10. If additional information is required from a provider, a letter will be mailed to the provider requesting additional information within 45 days of receipt of the dispute. The PDR is held open for an additional 30 working days in order to receive requested information

11. The Claims department maintains all pended receipts and handles responses and non-responses from providers within the required time frame.

12. All final determinations are noted on the tracking form and if the Provider Dispute is overturned or upheld, a determination letter will be mailed to the provider within 45 working days from the date of receipt of the dispute

13. When batch of PDRs have been completed, the Claims department closes the inventory batch in Inventory Control Database.

PDR Database

1. The PDR Database is an internal device that tracks and stores all provider dispute information outside of the claims processing system. This Access database is used to compile and report details of the Provider Dispute Resolution Mechanism established by Imperial Health Holdings Medical Group.

2. All information entered is “backed up” for security purposes.

3. The database is “field” protected. PDR information entered in the database cannot be deleted or altered once it is saved.

4. Reports can be generated to review all data using the PDR Database**.** These reports are generated on the basis of open or closed disputes.

5. The Claims Manager generates reports for monitoring timely acknowledgements and timely completion of disputed receipts.

Note: *The Provider’s Right to Appeal is indicated at the bottom of every Imperial Health Holdings Medical Group’s Explanation of Payment (EOP) issued to a provider.*

Copies of provider disputes and the determinations, including all notes, documents and other information used to reach its decision, shall be retained for a period of not less than ten years.

Reference(s)

- AB1455
- 42 CFR 405.940, 405.942, 405.962, 405.944, 405.964§1852 (a)(2)(A)

Attachment(s)

None

The Board of IMAS is ultimately responsible for supporting the Credentialing program but has delegated authority for implementation of the Program to the Health Plan Credentials Committee.

Contracted participating providers in the network, providing healthcare and services to health plan members must be credentialed. The scope of credentialing includes, but is not limited to: MDs, DOs, DDS, DPMs, and DCs.The credentialing process may also be extended to physicians who are not contracted by the health plan, but who provide coverage for network practitioners. The credentialing and recredentialing of Allied Health Professionals is also included under the scope of the Credentialing Program. This includes LCSWs, Psychologists and MFTs.

Providers are listed in the IMAS Provider directories ONLY after their credentialing has been completed.

Formal selection and retention criteria does not discriminate against health care providers who treat high-risk or high-cost populations and credentialing and recredentialing decisions are not based on criteria of race, religion, gender, age, ethnicity, nationality, sexual orientation or patients (e.g., Medicaid) in which the practitioner specializes. Committee members must sign an attestation form incorporating the above criteria. If complaints regarding discrimination are received from a provider (either verbally or in writing), the matter will be reviewed by the Credentials Committee and referred to the QM department for further evaluation and action. Additionally, procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to:

- Periodic audits of credentialing files (in-process, denied and approved files) to ensure that practitioners are not discriminated against;
- Periodic audits of practitioner grievances/complaints to determine if there are grievances/complaints alleging discrimination;
- Monitoring involves tracking and identifying discrimination in credentialing and recredentialing process; and
- Maintaining a heterogenous Credentialing Committee membership.

IMAS will monitor the effectiveness of the credentialing and re-credentialing processes at least annually for all credentialing activities delegated to contractors.
Credentialing will commence when providers have signed attestations stating that they are not excluded from Medicare/Medicaid participation and/or have chosen not to opt out of Medicare/Medicaid. For providers who are recredentialing, each Credentialing Coordinator will review the appropriate State or Federal website to ensure that providers have not opted out between cycles.

Additionally, IMAS has policies and procedures for the initial and ongoing assessment of organizational entities with which it contracts. This includes, but is not limited to hospitals , skilled nursing facilities, home health agencies and freestanding surgical centers. Assessment is required when the contract is initiated and every three years thereafter.

The scope of the Credentialing Program includes policies that define the oversight and/or credentialing/recredentialing of non-physician extenders, i.e., Physician Assistants, Nurse Practitioners, Certified Nurse Anesthetists and Certified Nurse Midwives. Oversight functions include documentation of valid current licensure and malpractice insurance for both physician and physician extenders to be kept on file with the Credentialing Department. An attestation form confirming compliance with all laws, regulations, standards and contract provisions will be signed by the supervising physician and physician extender and kept on file with the department. Credentialing/Recredentialing functions are included under the Credentialing/Recredentialing Process portions of this document.

Committee Structure

The Credentials Committee will be comprised of the Chair, currently an IMAS Chief Health Officer (CHO), and at least *two* additional physicians: IMAS participating physicians. Imperial Health is comprised of a range of participating practitioners. The Chair is accountable for the credentialing function with the support of the Senior CHO and the Credentials Manager. The Credentialing Chair is available on a daily basis to provide consultation/direction for Credentialing staff in implementing the credentialing processes. The Credentialing Chair also attends the Board of Directors meetings, chairs the QI Committee and UM Committee and attends Managers Meetings, providing linkage between the various components of medical management functions. The Chair is diligent in providing appropriate formal follow-up to participating providers.

IMAS Committee meetings are only conducted with a quorum (3), consisting of the Chair and a simple majority of the Committee physicians. Only physician members are voting members. Non-physician members may include the Managers of Medical Management and the Manger of Credentials or Credentialing Coordinator.

Additionally, the Committee may consult any member on a call list of specialists maintained by the Credentialing Department for input and evaluation of credentialing and/or recredentialing applicants.

The Credentials Committee is scheduled to meet on a quarterly basis and will take Committee action as needed. Minutes are completed for review and signature by the Credentials Chair prior to the next Credentials Committee meeting and stored in a locked cabinet, with access limited to the CHO and Credentials staff.

The Credentials Committee, with the cooperation of the Credentials staff, will maintain copies of all applications, verification reports, office site and medical record audit worksheets, and other data within the provider file. These files are stored in locked cabinets in the Credentials Department and access to the files is limited to Committee physicians during the meetings and Credentialing/QI staff on an as needed basis. Quality/peer review information is maintained in separate files.

Committee Objectives

The objectives of the Credentials Committee are to develop provider networks with health care practitioners meeting established standards of credentialing and re-credentialing.

- To objectively assess credentialing information on all providers against established standards prior to being contracted as part of the provider network.
- To objectively assess re-credentialing information and performance on all providers against established standards every three years.
- To develop and recommend new policies and procedures as needed to meet or exceed the regulatory standards for demonstration of professional competence and verification of other relevant credentialing information.
- To provide a confidential forum for review, discussion, and determination of clinical care issues by committee peers resulting in education, disciplinary actions as appropriate, improved physician performance, and improved patient care.
- To provide oversight on all credentialing and re-credentialing activities.
- To provide oversight for office site review activity as a component of credentialing and re-credentialing.

- To annually review and evaluate the effectiveness of the Credentialing Program.

Confidentiality

Individuals engaged in credentialing activities shall maintain confidentiality of the information disclosed inherent with responsibilities of Committee membership. A "statement of confidentiality" is signed by each physician member and IMAS staff member. The credential staff members also sign confidentiality statements as a condition of their employment and are issued restricted, confidential passwords for on-line credentialing and any interfaces with a possible delegated credentialing organization.

Physician files are kept in locked cabinets, accessible only to Committee physicians during the Credentialing Committee Meetings and Credentialing staff.

Conflict of Interest

No person may participate in the review and evaluation of any case in which she/he has been professionally involved or where individuals who have a business, family, or professional relationship with such a person are involved.

Peer Review

It is the objective of peer review to provide a confidential forum with non-discoverable transaction records in which the discussions of peers and examination of clinical records may lead to enhanced education of the participants, improved physician performance, physician sanctioning as appropriate and improved patient care.

Government/Health Plan Access to Peer Review

Federal and State representatives are allowed minimal access to blinded peer review data as part of the oversight function. All representatives must sign confidentiality statements prior to auditing/reviewing Credentialing information.

Credentialing Process

The credentialing requirements/criteria for contracted participating physicians are as follows (the requirements for allied health professionals are implemented as applicable):

- Completed State Participating Physician Application including the signed attestation statement by the applicant regarding:
    - Ability to perform the essential functions of the position
    - History of loss of license and/or felony convictions
    - History of loss or limitation of privileges or disciplinary activity
    - Attestation to the correctness and completeness or the application
    - Lack of present illegal drug use
    - Authorization to release information for the verification of credentials
    - History of professional liability claims

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    - All applications must be completed within 90 days of receipt, including Credential Committee Approval.
- Material omissions and /or misrepresentations may result in immediate denial of the application, or termination of privileges, employment or physician participation agreement.
- The highest level of education will be verified for Practitioners; Refers to MD, DO, DPM, PhD, DDS, MFT, LCSW, PA, NP.
- Online primary source verification of Board Certification is obtained within 180 days of Committee determination from the American Board of Medical Specialists (ABMS) or the appropriate certifying Board.
- On-line verification is obtained from the American Osteopathic Association for DOs.
- Primary source verification of educational Medical Company Name (medical school, residency or fellowship training) is required and obtained within 180 days of Committee determination for those practitioners who are not Board Certified.
- Only the highest levels of education must be verified (e.g., residency, fellowship as appropriate). This may be obtained through the American Medical Association (AMA) Physician Master File.
    - If an agent of an approved source (e.g., National Student Clearinghouse (NSC)) is used documentation of the contractual relationship between it and the approved source (i.e., institutions that work with the approved source) that entitles the agent to provide verification of credentials on behalf of the approved source. Documentation of this contractual relationship (e.g., contracted list, screen shot of contract relationship) will be included in the file.
- Online primary source of verification of malpractice history of past or pending suits is obtained from the National Practitioner Data Bank (NPDB) within 180 days prior to Committee determination. NPDB query is not required for chiropractors and podiatrists, however, queries are completed.
- Primary source verification of clinical privileges at the hospital designated by the practitioner as the primary admitting hospital is obtained from the hospital within 180 days prior to Committee determination. Any limitation of privileges must be noted, and confirmation of clinical privileges in good standing is required. A physician is not required to have clinical privileges to be credentialed but must state in writing who is providing inpatient coverage, or it must be noted that a hospitalist program is in place.
- A copy of the certificate of insurance face sheet is required, showing professional malpractice coverage meeting mandated State levels, effective at the time of the Committee determination.
- Verification of current DEA or CDS certificate is completed through a copy of the certificate, effective at the time of the Committee determination. This is done during both the initial/recredentialing cycle. Additionally, DEA validation is part of our Ongoing Monitoring and as such, the active database is queried on a monthly basis to identify any providers with administrative actions.
- Primary Source verification from the applicable State Medical Board and/or a copy of unrestricted State license from the practitioner is obtained within 180 days of Committee determination. For practitioners other than MDs, primary verification must be obtained from the appropriate state licensure agency.
- Online primary source verification of Medicare and Medi-Cal Sanction status is

obtained within 180 days of Committee determination through querying NPDB and/or Federation of State Medical Boards (FSMB).

- For initial credentialing, re-credentialing and ongoing monitoring and reporting of sanctions, verifications shall be verified through Streamline Verify monthly via https://dmf.streamlineverify.com/search. The following websites are verified through Streamline Verify: Federal OIG, System Award Management (SAM), California Medi-Cal Suspended, California OIG, Medicare Opt-Out, & NPPES NPI Registry.
- Primary source verification of HIV/AIDS Specialist status is obtained through the American Academy of HIV Medicine (AAHIVM).
- Online primary source verification of state sanctions, restrictions and/or limitation on scope of practice is obtained through the FSMB or query of the appropriate state licensure agency within 180 days of Committee determination.
- References from licensed physicians are required on the application. References may be verified if additional verification of competence is needed.
- Work history of at least 5 years as demonstrated on application or Curriculum Vitae. Any gap in work history beyond six months should be verified orally, and gaps of one year or more should be verified in writing by the practitioner.
- CLIA certificate if required at all facilities to perform any laboratory tests. While this may not be a requirement in all states, IMAS will run a query on all providers during the initial/re-credentialing process.
- Social Security Death Master File (SSDMF) during the initial/re-credentialing cycle verification shall be performed on each provider during the initial credentialing process and the re-credentialing cycle. Verifications shall be verified at: https://dmf.streamlineverify.com/search
- Medi-Cal Enrollment Verification is validated with California Health and Human Service Open Data Portal Fee for Service or the Ordering, Referring and prescribing (ORP) at initial credentialing and re-credentialing.
- **NOTE:** Provider will not be credentialed if they are currently Opted-Out of Medicare.
- **EXPIRABLES -** As a basis to ensure compliance, a report is generated on a monthly basis to identify practitioners whose malpractice, DEA, license, or board certification is due to expire. The Credentials Assistant will contact the practitioner to obtain updated documents and update the Credential file.

Practitioner Right to Review Information

Practitioners are notified of their right to review and correct erroneous information obtained in the credentialing or re-credentialing process. This includes information obtained from any outside primary source (state licensing boards, malpractice insurance carriers). The right to review does not extend to references or recommendations or other information that is peer review protected or if disclosure is prohibited by law. They may also ascertain the status of their application or reapplication at any time.

If credentialing information obtained from other sources varies substantially from that provided by the practitioner, the Credentialing Coordinator will notify the practitioner in writing for their response within five working days or less. A written response is required from the practitioner to be sent to the appropriate Credentialing Coordinator and this information is placed in the chart for review at the time of credentialing/re-credentialing.

Practitioners are notified of these rights in the Provider Manual, in the CHO's communication to practitioners and in cover letters sent to initial applicants and those who are re-credentialing.

Committee/Chief Health Officer Determination

Upon receipt of the required credentialing information, the CHO (for level 1 applicants) and the Credentials Committee (for level 2 applicants) will review and approve the applicants.

Level 1 applicants are presented to the CHO for review and approval. Level One Providers meet all the pre-established criteria for credentialing with no adverse information reported from any primary or other secondary source. There are no active suits or suits pending.

Level 2 completed applicants meet the credentialing criteria but some adverse information has been reported from a primary or other secondary source, there is a new suit, or a suit is pending. *Level 2* applicants will be pre-reviewed by the Chief Health Officer and then presented to the *Imperial Management Administrators Services (IMAS) Credentials Committee for* review and approval. The Chief Health Officer may also approve certain Level 2 applications.

The applicant will be formally notified by letter within 60 days of the CHO/Committee's determination.

The Credentials Committee may recommend that the applicant not be approved due to the provider's conduct or professional competence that may compromise patient safety or the quality of patient healthcare. The applicant will be notified in writing by the Credentials Committee of the reason for such action. Notification to the applicant will be sent within 60 working days.

If the applicant reapplies at some other time, his/her application will be processed as an initial application.

Screening of Excluded Individuals and Downstream or Related Entities

The IPA/Medical Group shall ensure that employees and/or downstream subcontracts and/or related entities are not sanctioned, debarred, suspended, or excluded from participation in Medicare or Medicaid under Sections 1128 or 1128A of the Social Security Act.

The IPA/Medical Group must ensure it has screened its employees and/or subcontractors as required by CMS prior to employment or contracting and at least monthly thereafter against the CMS required exclusion lists: DHHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Service Administration/System Award for Management (SAM) Excluded Parties Lists Systems (EPLS).

NOTE: Medicare requires the IPA/Medical Group to ensure that no payments are made with respect to any item or service (other than an emergency item or service) furnished by an individual or entity when such individual or entity is excluded from participation in Medicare/Medicaid programs (including Medicare Advantage plans).

Site Audit and Medical Records Review

Office site visits are required as part of the initial credentialing process for all Primary Care Physicians (PCPs). This includes a physical inspection including, but not limited to safety issues,

policies and procedures in place for office, protocols, emergency capabilities and medical record keeping organization. Standards of compliance have been determined as part of this policy at 90% and the results are incorporated into the initial determination for these providers. Outcome letters are sent to the practitioners notifying them of the results and possible opportunities for improvement. Audit tool results are maintained in Credentials files and or Provider Relations files. State Site Audit results may be accepted in lieu of the IMAS audit.

Re-credentialing

Participating providers must satisfy re-credentialing standards required for continued participating in the network. Re-credentialing is completed within three years from the last Re-credential cycle. Providers are Re-credentialed no more than 36 months maximum to maintain compliance.

Primary Source verification of medical licenses, DEA certificates, and malpractice forms will be kept current between re-credentialing cycles. Each form is tracked by expiration date.

The requirements for re-credentialing are:

- CAQH Application, Imperial Profile and W9. The CAQH must have a valid attestation date by the applicant.
- Board Certification if the practitioner states that he/she is board certified. Verification of board certification for chiropractors is not required.
- Online primary source verification of malpractice history of past or pending suits is obtained from the NPDB within 180 days of Committee determination. This does not apply to chiropractors and podiatrists.
- Primary source verification of clinical privileges at the hospital designated by the practitioner as the primary admitting hospital is obtained from the hospital within 180 days of Committee determination.
- Primary source verification of professional malpractice coverage meeting applicable State Standards and /or a copy of the certificate of insurance face sheet, effective at the time of the Committee determination.
- Verification of DEA certification effective at the time of the Committee determination.
- Online primary source verification of medical license from the State Medical Board is obtained within 180 days of prior to Committee determination.
- Online primary source verification of Medicare and Medical Sanction status is obtained within 180 days of Committee determination. This is obtained through NPDB and/or FSMB online query.
- Online primary source verification of state sanctions, restrictions and/or limitations on scope of practice is obtained through the FSMB or query of the appropriate state licensure agency within 180 days of Committee determination.
- Medi-Cal Enrollment Verification is validated with California Health and Human Service Open Data Portal Fee for Service or the Ordering, Referring and prescribing (ORP) at initial credentialing and recredentialing.

The re-credentialing process also includes appraisal of the following data in its re-credentialing decision-making process for primary care practitioners:

- Member complaints and grievances, concerns, non-compliance with the program
    - Practitioner and organizational provider complaints are reviewed and resolved upon receipt by the Appeals and Grievances Department. When appropriate, complaints will be forwarded to the applicable Health Plan upon receipt.

- Information from quality improvement/utilization management activities

Upon receipt of the required re-credentialing information, the CHO and/or Credentials Committee will make recommendations as to the acceptance or rejection of provider applicants. Applicants will be formally notified within 60 days by letter of the determination.

In the event of Recredentialing documents not retuned timely an email will be submitted to the provider stating the following:

- If the application is not returned within the designated time period, you will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork.
- Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment shall be deemed a voluntary resignation for Imperial Management Administrator Services and you will be submitted as "Inactive" to the Credentials Committee.
- Please do not hesitate to contact me directly if I can be of assistance in order to expedite this.
- Please ensure the CAQH is active and currently updated.

Behavioral Health Practitioners (California)

For California practitioners who provide service that treat mental health and substance abuse disorders whose contracts were issued, amended or renewed on or after January 1, 2023, IMAS will:

- Assess and verify the qualifications within 60 days after receiving the completed credentialing application; and
- Provide notification to the applicant within seven (7) business days of receipt of the application by the Credentialing Department to verify receipt and inform the applicant whether the application is complete.

Termination of Participating Physicians

The Committee is responsible for an objective assessment, discussion, and recommendation of the physician's status, taking into consideration all submitted re-credentialing information and the best interest of IMAS and the patients.

Procedures will be followed as defined in the IMAS Reduction, Suspension and Termination of Provider Policy (005). IMAS has an appeal process when the practitioner's participation with HP has been altered based on issues of quality of care and/or service. Refer to the IMAS Credentialing Fair Hearing Policy (002).

Health Delivery Organization Quality Assessment

A mechanism is in place to ensure that organizational providers are assessed prior to contracting and on a regular basis, every three years, thereafter. This process applies to acute care hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, rehabilitation facilities, psychiatric hospitals, labs, outpatient physical and speech therapy centers and renal dialysis centers, hospices, outpatient diabetics self-management training, portable x-ray supplier,

rural health clinics, federally qualified health centers and residential and ambulatory behavioral health facilities. These policies include meeting state and other regulatory requirements necessary for the entity accreditation status. Site visits are required if there is no accreditation status and the Credentialing Committee may recommend a site visit based upon their review of the information received when the required components have been met.

Upon receipt of the Health Delivery Organization (HDO) application, it is reviewed for completeness of the required documentation. All applications are completed within 60 days.

If the provider is not able to provide the components stated under entity requirements, the Credentialing Committee may use diligence in recommending approval based on information submitted and reviewed, and the need of the facility for patient care and limitation of other, existing comparable facilities.

For initial HDO credentialing and re-credentialing and ongoing monitoring and reporting of sanctions verifications shall be verified through Streamline Verify monthly via https://dmf.streamlineverify.com/search. The following websites are verified through Streamline Verify: Federal OIG, System Award Management (SAM), California Medi-Cal Suspended, California OIG, Medicare Opt-Out, & NPPES NPI Registry.

Standards:

A. Hospitals ***(which may include psychiatric services and outpatient services such as speech, physical and occupational therapies and dialysis etc. as defined under state licensure)***

- JCAHO/NCQA Accreditation
- State licensing
- Assigned Medicare number
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

B. Skilled Nursing Facilities

- State Licensure
  Assigned Medicare number
- JCAHO/CCAC/CANHR/or Medicare survey accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

C. Free Standing Surgical Center

- AAAHC/ JCAHO Accreditation/Medical Quality Commission
- State Licensure (If applicable)
- Assigned Medicare number
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)

- QI Complaints

D. Home Health

- State Licensure
- Assigned Medicare number
- JCAHO/ AAAHC/CHAP accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

E. Rehab Facilities and/or Outpatient Physical and Speech Therapy Centers

- State Licensure
- Assigned Medicare number
- Appropriate Accrediting Entity
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

F. Psychiatric Hospitals

- State Licensure
- Assigned Medicare number
- JCAHO/NCQA Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

G. Laboratories

- State Licensure
- Assigned Medicare number
- College of Pathologists Accreditation or other Appropriate Accreditation
- CUA Certificate or waiver
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

H. End Stage Renal Disease Services

- State Licensure
- Assigned Medicare number
- CUA Certificate
- JCAHO /CMS/OHS Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)

- Professional Liability Insurance ($1M/$3M)
- QI Complaints

I. Hospice

- State License
- Assigned Medicare Number
- JCAHO/ACHC Accreditation/Or other appropriate Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

J. Mobile X-Ray Supplier

- State License
- Assigned Medicare Number
- ACR Accreditation/Or other appropriate Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

K. Federally Qualified Health Center (FQHC)

- State License
- Assigned Medicare Number
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

L. Durable Medical Equipment

- State License
- Assigned Medicare Number
- Board of Certification/Accreditation/JCAHO/Other appropriate Accreditation
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M) (If applicable)
- QI Complaints

M. Residential and Ambulatory Behavioral Health Facilities

- State License
- Assigned Medicare Number
- JCAHO/Other appropriate Accreditation
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M) (If applicable)
- QI Complaints

Allied Health Professionals/Physician Extenders

At least every three years, the IMAS Credentials Committee confirms that the provider entity continues to be in good standing with the state and regulatory bodies. At the time of reassessment, the QI Department is requested to query their grievance tracking log for possible quality of care or service issues. The Credentials Committee reviews this information as part of the assessment process.

Allied health professionals are specially trained professionals, licensed by the State, who provide specialized health care services. This group includes psychologists, MFTs, and LCSWs. Allied health professionals contracted with IMAS will be expected to provide health care services within the scope of practice as defined by their State licensing body or professional association.

Minimum credentialing/re-credentialing requirements are as follows:

- Verification of state or professional license to practice within 180 days of Committee review
- Verification of Board Certification related to specialty within 180 days of Committee review
- Verification of current valid professional liability insurance within 180 days of Committee review
- Completed application which includes professional training, permission for release of information, attestation statement, release of information statement and professional references
- Work history of at least five years as demonstrated on application or CV
- Professional liability claims history of at least five years
- Sanction reports from NPDB or appropriate licensing agency

Completed re-credentials files will be reviewed and approved by the Credentials Committee. Allied health professionals have the same appeal rights and right to review information received during the Credentialing process as stated earlier in this document.

Physician Extenders are specially trained individuals who provide medical services under the supervision of their Physician supervisors.

Delegated Credentialing

IMAS is accountable for oversight and documentation of the Credentialing activities delegated to contractors. Delegation oversight will include:

- Pre-delegation audit of Credentialing policies and procedures (must comply with current NCQA criteria) and a file audit of initial and re-credentialing files according to the 8/30 rule.
- The credentialing activities which are delegated and for which the contractor is responsible.
- The reporting requirements of IMAS.
- The Program's continued approval of the delegated contractors credentialing program and activities.

The Credentials Committee has the right to approve new providers and to terminate or suspend individual providers. Additionally, IMAS must monitor the effectiveness of the credentialing and re-credentialing processes at least annually.

Program Evaluation

The Credentialing Program shall be evaluated and revised as necessary at least annually by the Credentialing Committee and the Board of Directors to ensure that it meets or exceeds established regulatory standards of credentialing and re-credentialing.

REFERENCES

- Applicable State and/or Federal regulations, Accreditation Standards, Contracted Health Plans
- California Bill AB 2581, CA HSC § 1374.197

ATTACHMENTS

None

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Subject: Medi-Cal Provider Dispute Resolution	**Policy Manual:** Imperial Health Holdings Medical Group
Effective Date: May 1, 2016	**Policy Number(s):** 05-01-16-07-0017
Reviewed Dates: N/A	
Revision Dates: 04/14/2024	**Department: CLAIMS**
	Title: President/Chief Medical Officer/Medical Director
Last Revised by: N/A	**Approval Signature:** On File

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

This policy applies to the Medi-Cal line of business.

PURPOSE

To set forth the policy and procedure for processing all provider claims disputes.

POLICY

It is the policy of Imperial Health Holdings Medical Group to adhere to requirements specified in Sections 1300.71 and 1300.71.38, California Code of Regulations Title 28, Claims Settlement Practices and Dispute Resolution Mechanism, when processing provider claims disputes. Imperial Health Holdings Medical Group shall not impose a deadline for the receipt of a dispute that is less than 365 days from the last date of action.

PROCEDURE

1. Types of Provider Dispute Resolution (PDR) issues. Provider disputes that are submitted to Imperial Health Holdings Medical Group may contain requests to review the following types of issues:

    a. Claim payment or denial. Provider disputes payment or denial of claim for any reasons including timely submission, request for retroactive authorizations, eligibility, etc., are tracked through the PDR Database within the Claims Department.

b. Disagreement with request for overpayment. Provider disputes a request for reimbursement of an overpayment of a claim. The dispute is logged in the PDR database and acknowledged. The dispute is routed to Claims Revenue Recovery for research. Once it is finalized, it is returned to the Claims Specialist for the resolution letter.

c. Contract/DOFR interpretation disputes. When a provider dispute arises from a difference in understanding of a contractual interpretation, fee schedule or any term and condition of the contract, the dispute is reviewed and researched by the Claims Department and when research complete resolution letter is issued.

d. Denial of authorization for "pre-service" requests. When a pre-service dispute is received within the Claims Department, it is directed to the Network UM Department for review and retro-authorization determination. Once claim is received back from UM Department the Claims department issues a resolution letter.

2. Required submission of information. The provider must utilize the PDR Request Form a written notice that contains, at a minimum, the following information:
    a. Provider's name;
    b. Provider's identification number;
    c. Contract information; and
    d. A clear explanation of the disputed item, the date of service and a clear identification of the basis upon which the provider believes the payment amount, request for additional information, and request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

3. Receipt of claims. The Claims Mailroom Unit receives all Claims Department mail and is responsible for the sorting, batching, date stamping and inventory of all claim receipts.
4. Provider dispute must be acknowledged within 2 working days if submitted electronically or 15 working days if submitted in paper
5. IHHMG shall not impose a submission deadline of less than 365 days from action or in case of inaction, no less than 365 days after the time for contesting or denying a claim has expired
6. Resolution of Provider Dispute must be made in writing within 45 working days from the receipt of dispute
7. Whenever a payer contests, adjusts or denies a claim it shall inform the provider of the ability to dispute and include the procedure for obtaining forms, along with mailing address for submission of disputes

Initial Review

1. For paper claim disputes, the Claims department makes the initial determination of provider dispute(s) and sends acknowledgement letter(s) within fifteen (15) working days from date received. For electronic claim disputes an acknowledgement letter is sent within two (2) working days from date received.

2. If the Claims department determines that the submitted information is not a PDR, the information is forwarded to Claims Mailroom Unit for batching to Claims Examiners.

3. The Claims department enters the disputed information into the Imperial Health Holdings Medical Group Provider Web Portal. Information from Imperial Health Holdings Medical Group portal is automatically transferred to PDR Database.

4. The database automatically generates an acknowledgement letter based on the data entered above. Once this letter is issued, the data cannot be altered. Acknowledgment letters are sent the same day they are generated.
5. The Claims Specialist prints a tracking form that is generated by the database for each PDR submission. The tracking number is noted in the claims system history for cross-reference.

6. The Claim Specialist batches the PDRs by received date and enters received date and claims count into Inventory Control Database for inventory tracking.

Final Determination

7. The Claims department reviews PDRs based on oldest date on hand.

8. The Claims department reviews the details submitted by the provider to determine if Imperial Health Holdings Medical Group initial, decision should be overturned or upheld.

9. If a dispute is in favor of the provider, payment is issued to the provider within five (5) working days of determination. All applicable interest owed is included in the payment.

10. If additional information is required from a provider, a letter will be mailed to the provider requesting additional information within 45 days of receipt of the dispute. The PDR is held open for an additional 30 working days in order to receive requested information

11. The Claims department maintains all pended receipts and handles responses and non-responses from providers within the required time frame.

12. All final determinations are noted on the tracking form and if the Provider Dispute is overturned or upheld, a determination letter will be mailed to the provider within 45 working days from the date of receipt of the dispute

13. When batch of PDRs have been completed, the Claims department closes the inventory batch in Inventory Control Database.

PDR Database

1. The PDR Database is an internal device that tracks and stores all provider dispute information outside of the claims processing system. This Access database is used to compile and report details of the Provider Dispute Resolution Mechanism established by Imperial Health Holdings Medical Group.

2. All information entered is “backed up” for security purposes.

3. The database is “field” protected. PDR information entered in the database cannot be deleted or altered once it is saved.

4. Reports can be generated to review all data using the PDR Database**.** These reports are generated on the basis of open or closed disputes.

5. The Claims Manager generates reports for monitoring timely acknowledgements and timely completion of disputed receipts.

Note: *The Provider’s Right to Appeal is indicated at the bottom of every Imperial Health Holdings Medical Group’s Explanation of Payment (EOP) issued to a provider.*

Copies of provider disputes and the determinations, including all notes, documents and other information used to reach its decision, shall be retained for a period of not less than ten years.

Reference(s)

- AB1455
- 42 CFR 405.940, 405.942, 405.962, 405.944, 405.964§1852 (a)(2)(A)

Attachment(s)

None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Imperial Management Administrative Services		Policy and Procedure No:	PNO:009
		Department:	Provider Network Management
Signature:	Provider Network Management	Title:	Provider Network Training
	Giuletta Rudon	Effective Date:	01/01/2023
Date:	01/30/2023	Reviewed/Revised Date:	03/01/2024

I. BACKGROUND

Imperial Health Holdings Medical Group ("IHHMG") through its delegate, Imperial Management Administrative Services, ("IMAS") shall follow the procedures set forth in this policy with respect to every contracted California network provider.

II. PURPOSE

To document the oversight process to ensure that all contracted network providers, understand the requirements of both federal and state law with respect to the delivery of medical care in California.

III. POLICY

Newly contracted providers will receive training on key public health linked programs and services available to patients, including program training requirements for participation in federally funded programs. IMAS shall also provide annual and recurring training to network providers on federally funded programs as well as California specific training programs.

Training may be completed by participation in IHHMG's sponsored training programs, a classroom setting, in-service, one-on-one training, or the distribution of training materials for self-review.

IMAS shall confirm that within ten days of placing a newly contracted provider on the IHHMG active roster that the provider understands and acknowledges that they

participated in the following orientation-training programs:

- California Children Services (CCS)
- California Coordinated Care Initiative Care Coordination Standards
- Child Health and Disability Program (CHDP)
- Cultural & Linguistics Training
- Cultural Competency and Disability Training
- Disability Literacy Training
- False Claims Act
- Fraud, Waste and Abuse
- Health Insurance Portability and Accountability Act (HIPAA) Training
- Interdisciplinary Care Team Training
- Initial Health Assessment/Health Risk Assessment
- Long Term Support Services
- New Provider Orientation Trainings
- Special Needs Plans (SNP) Model of Care Training

In addition, IMAS also provides initial and recurring training to network providers on the following:

- Provider Communications
- Enrollee Rights (including there will be no balance billing)
- Policies and Procedures
- Claims submission and payment.
- Identifying and reporting abuse, neglect, exploitation, and critical incidents
- Coordination of Benefits
- Special Needs Plans (SNP) Model of Care Training
- Fraud, Waste and Abuse
- Health Insurance Portability and Accountability Act (HIPAA) Training

IV. PROCEDURE

1.1. Within 10 days of placing a newly contracted provider on the IHHMG roster, IMAS will ensure that all network providers are trained where mandated by federal and California specific laws. The training documents will include an attestation whereby the network provider acknowledges that they've (i) reviewed the training material, (ii) understand the materials in which they reviewed and (iii) will comply in all respect with the requirements set forth therein, including all federal and California specific requirements in connection with the delivery and reporting of medical care while treating IHHMG's patients. The Provider Network Management Department will ensure the distribution of the individual plans for training materials, including required documentation and attestations for review.

1.2. Attached to the materials will be a coversheet to explain to the provider the requirement for review, participation, and compliance with the program. This document will also instruct the due date for completion and location to return the attestation.

1.3. The Provider Network Management Department will maintain distribution logs to document the date of distribution and the date the attestation is returned to IMAS.

1.4. Upon the receipt of the signed attestation verifying that the provider has completed the training materials, the Provider Network Management Department will inventory the attestation in the Provider Record for future reference and to determine when the following annual trainings must be executed in accordance with this Policy.

1.5. For any provider that does not return the attestation on time, a follow-up to the provider is made.

1.6. If the provider fails to return the training attestation, the provider will receive written notice and further instructions including compliance implications for failure to respond.

1.7. After written notice, if the provider continues to fail to return the attestation, the Provider Network Management Department Director shall report such non-compliance to the Quality Management Committee who will be required to take further action, which may include suspension or termination from the network.

2. Annual trainings will be calendared and performed within 12 months of the last training session.

3. Upon contracting, each provider's staff will be trained on the required training programs.

Sign-in sheets from on-site training will be maintained by the Provider Network Management.

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Policy Name: Network Accessibility to Providers, access to appointments for PCP , Behavioral Health, Specialty Care.	**Policy#:** Access and availability
Line of Business: [x] **Medicare (CSNP/DSNP),** [x] **Medicaid,** [ ] **Commercial,** [ ] **Exchange**	
Effective Date:1/1/2024	**Revision Dates: 1/1/2024**
Department Name: Provider Network Management	
Department Leader: Giuletta Rudon	**Date:** 01/01/2024
Committee Approval:	**Date:**

DEFINITIONS:

Provider – Primary Care, Behavioral Health & Specialists
Standards – Guidelines approved by DMHC and CMS and NCQA to assess the accessibility of providers.

PURPOSE:

Refine Imperial Health Plan's (IHP) process to assess and mitigate the risk presented to our members by contracted providers within our network. Oversee the participating providers are offering members access to covered services in accordance with Imperial Health Plans Access to Care Standards and solicit their feedback and/or concerns through an annual provider survey.

POLICY:

This policy applies to Primary Care Physicians (PCP), Specialists (SCP), Behavioral/Mental (BH/MH) Healthcare Services, Ancillary and Dental Care Providers. Imperial will gather accurate demographic information on our providers. Survey IHP's provider network performance in themes of quality, patient experience, and disputes. Take corrective action to establish/meet the expectations of our providers.

Wait Times

- When a provider's office receives a call from an Imperial Health Plan member during regular business hours for assistance, the provider or other healthcare professional must either take the call within 30 seconds or call the member back within 30 minutes of the initial call.

- When an Imperial member calls a physician's office, hold time should not exceed 10 minutes.

- When and Imperial member arrives on time for an appointment, the member should be seen within 15 minutes of the scheduled appointment.

Follow-up of routine care for Behavioral Healthcare

Behavioral Health providers must have appointment availability to for routine follow-ups for members within 30 days, for non-prescribers within 20 days.

- Reasonable access data will be monitored through complaint data analysis.

Interpreter

Interpreter services must be coordinated with scheduled appointments for health care services to ensure availability at the time of appointment.

24/7 Access to Covered Services

Participating providers are responsible for offering Imperial Health Plan Members access to services covered 24/7. Access includes regular office hours on weekdays and the availability of a provider or other health care professional after regular office hours, on weekends and holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. Providers are also required to meet appointment access standards as described below.

PROCEDURE:

Providers with highest volume are surveyed and evaluated first. Providers with lower membership will be surveyed secondarily using the access to appointments and after-hour care survey. (Attachment A).

After-hours call

- The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be immediately directed to dial **911** or to proceed directly to the nearest emergency room.

- If staff or answering services is not immediately available, an answering machine may be used. The answering machine or auto-attendant message must immediately direct the caller to dial **911** or go directly to the nearest emergency room. The message must also give members and alternative contact number or direct transfer or call back feature so they can reach the primary care physician (PCP) or on-call provider with a medical concerns or questions.

- Non-English-speaking members who call their PCP after hours should expect to get language-appropriate messages. In the event of an emergency, these messages should direct members to hand up and dial 911 or to proceed directly to the nearest emergency room.

- In non-emergency after-hours situations, members should receive instructions on how to contact the on-call provider.

- All calls taken by an answering service must be returned.

Monitoring

- Monitoring will be conducted via Provider Appointment Access Surveys at a minimum yearly occurrence and through patient surveys and complaints tracking.

- Results of monitoring and evaluation are communicated to staff and providers along with education as appropriate.

- Access standards must be 90% Compliant or above. If any of the Access Standards are found to be non-compliant the provider will be subject to increased monitoring and notified in writing with a request for a corrective Action Plan which must be submitted within 30 days of notification.

- Follow-up on the recommendation will be carries out as directed until issue(s) are resolved.

- Evaluations and corrective action reports will be gathered and reported to Provider Oversight's Quality Management Committee and the Governing Body.

Corrective Action

Imperial Health Plan (IHP) will carry out prompt investigation and corrective action when compliance monitoring determines the that (IHP) is not sufficient in ensuring patient access to care within the appropriate time frame, including but not restricted to taking all necessary and action were appropriate, to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance.

Imperial Health Plan shall give advanced written notice to all contracted providers affected by a corrective action who are deemed to be non-compliant by state, federal, NCQA access, and availability standards which will include:

- Clear descriptions of any identified deficiencies
- Coherent justification for the corrective action

- Provider shall be given the name and contact information of the authorized representative to respond to any concerns to regarding IHP's corrective action.

REGULATORY REFEERENCES:

MCM CHAPTER 4: SECTION 110

42 CFR 422.112

NCQA STANDARDS

POLICY ATTACHMENTS:

ATTACHMENT A – STANDARDS

Access to Care Standards for PCP's and SPC's

General Appointment	Standard
Emergency examination	Immediate access, 24/7 (Maybe directed to go to the emergency room or to hang up and call 911)
Access to non-urgent appointments with a primary care physician (PCP) for regular and routine primary care services	An appointment is offered within 10 business days from the time of the request.
Initial Health Assessment	For members 18 months of age and older, within 120 calendar days of enrollment
	For Medicare members, within 90 days of enrollment
Routine Prevention Exam	Within 30 calendar days of the request for an appointment
Access to urgent care services with a PCP that do not require prior authorization – (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	An appointment is offered within 48 hours from the time of the request. (96 hours for services that require prior authorization)

First Prenatal Visit	Within 14 calendar days of the request for an appointment
Access to after-hours care with a PCP	The ability for a member to contact an on-call physician after-hours; return call within 30 minutes for urgent issues
	PCP provides appropriate after-hours emergency instructions
Access to non-urgent care appointments with a specialist	An appointment is offered within 15 business days from the time of the request (after appropriate PCP visit)
Access to urgent care services that require prior authorization with a specialist or other provider	An appointment is offered within 96 hours from the time of the request
Access to urgent care with a Specialist	The specialist should see the member within 24 hours of receiving the request.
Routine Care with a Specialist	The specialist should see the member within 15 business days from date of request.
Telephone Access	Telephone access for screening and triage is available 24 hours a day 7 days a week. Answering machines or answering service must include a message the member that if they are dealing with a life-threatening emergency, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer	The maximum length for a providers office staff to answer the phone is 30 seconds.
Medical Records	A copy of medical records and/or results of the visit should be sent to the PCP's office to allow continuity of care.
Shortening or Expanding Timeframes	Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally

	recognized standards of practice. If the timeframe is extended, it must be documented within the patient's medical record that a longer timeframe will not have a detrimental impact on the patient's health.
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness, or other health condition	An appointment is offered within 15 business days from the time of the request
Missed Appointments	Missed appointment must be documented in the medical record the day the missed appointment the members bust be contacted my mail or phone to reschedule win 48 hours.

Behavioral Health Access to Care Standards

Criteria	Standard
Life threatening/Emergency needs	Will be seen immediately
Non-Life-threatening emergency needs	Will be seen within 6 hours

Urgent needs exam	Within 48 hours
Routine office visit, non-urgent exam	Within ten 10 Business Days
Non-Physician Behavioral Health Provider: Routing office visit, non-urgent exam	Within ten 10 Business Days
After-hours care	Available 24 hours a day, 7days a week.
Telephone Access	Telephone access for screening and triage is available 24 hours a day 7 days a week. Answering machines or answering service must include a message the member that if they are dealing with a life-threatening emergency, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer	The maximum length for a practitioner's office staff to answer the phone is 30 seconds.
Standard for reaching a behavioral health professional	Imperial Health Plan through our contracted behavioral health providers is available to arrange immediate access to a behavior health professional.

Criteria	Standard
Skilled Nursing Facility	Skilled Nursing Facility services will be available within 5 business days of request
Intermediate Care Facility/Developmentally Disables (ICF-DD)	ICF-DD services will be available within 5 business days or request. (These services are provided by Skilled Nursing Facilities and Nursing Facilities where 24 hour nursing services are provided. `
Community Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment