Imperial Health Holdings Medical Group

Provider Manual 2017

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SECTION 1. INTRODUCTION

1.1 Imperial Health Holdings Medical Group (IHHMG)

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP (IHHMG)

Imperial Health Holdings Medical Group (IHHMG) is a health care service plan with a select network of providers based in Los Angeles County, Riverside County, San Bernardino County, San Diego County, Orange County, Kern County, Fresno County, Santa Clara County, and Alameda County with Hospital Coverage that will serve populations with Medicare Advantage or Dual Eligible Coverage.

The IHHMG is overseen by an executive board, a Medical Director, a Quality Management Committee, and a Public Policy Committee

1.2 Quality Management Committee

The Quality Management Committee is core to our business, and is responsible for Utilization Management (UM) and Quality Management (QM) functions. Utilization Management staff is familiar with pre-authorization processes required by each health plan contracted IHHMG. Our goal is to expedite referral requests from providers and approve them in one or two working days. Other Utilization Management functions include:

- Implementation of UM Program and Work Plan
- UM Reporting required by health plans
- Preparation for and Participation in UM Audits conducted by health plans
- Hospital Case Management
- California Children's Services (CCS) Case Management
- After-hours triage
- Other services as required by contracted health plans and regulatory agencies.

Quality Management staff monitors the quality of care provided by IHHMG providers and conducts quality assessment studies. Quality Management functions include:

- Implementation of Quality Management Program and Work Plan
- Practice pattern profiling and analysis
- Quality management studies and reports required by health plans
- Preparation for and Participation in QM Audits conducted by health plans
- Member complaints and grievances resolution
- Clinical provider complaints and grievances
- Credentialing and re-credentialing process
- Other services as required by contracted health plans and regulatory agencies

1.3 Provider Relations and Network Operations

Provider Relations (PR) is committed to being accessible to all contracted physicians on a daily basis. The representatives are responsible for answering inquiries and concerns from contracted providers and assist with resolution.

Provider Relations shall work with contracted providers to ensure that the provider has the necessary information, resources, and assistance to work with the IPA. The following are the responsibilities for Provider Relations:

- Provider Orientation to cover operations for Customer Service, Utilization Management, Claims, Eligibility, IPA rosters, and Quality Management.
- Provider Manual Distribution
- Issues Resolution involving authorizations, claims, eligibility, capitation, contracting
- Provider Education/Training
- Network Updates
- IPA or Health Plan Policy Changes/Updates

- Health Education Material Distribution
- Member Enrollment Issues
- Provider Complaints
- Assistance with Grievances

Provider Relations Department is available Monday-Friday from 9:00 a.m. – 5:00 p.m. Our contact information is follows:

• By phone: (626) 838-5100 Option 4 • By email: Providerrelations@imperialhealthholdings.com

1.4 Credentialing

This Department maintains Provider credentialing file in compliance with standards recognized and mandated by NCQA, contracted health plans and other accrediting agencies.

1.5 Enrollment and Eligibility

This Department processes eligibility lists (electronic or paper) from health plans, prepares and mails eligibility lists to Primary Care Providers, administers and reconciles eligibility.

1.6 Claims and Encounter Data Processing

The Claims and Encounter Data Department adjudicates, reviews, pays and analyzes claims, compiles claims timeliness reporting, participates in claims audits by health plans, and processes encounter data and report to health plans.

SECTION 2. IMPORTANT CONTACT NUMBERS

2.1 Imperial Health Holdings Medical Group Contact Numbers

Please refer to attached "Contact List."

2.2 Health Plan Contact Numbers

Health Plans	LOB	Member Services Contact Number	Website
Alignment HP	Medicare	(866) 634-2247	www.alignmenthealthplan.com
Blue Cross	Medical	(800) 407-4627	www.anthem.com/ca
Brand New Day HP	Medicare	(866) 255-4795	http://brandnewdayhmo.com/
Care1st HP	Medicare	(800) 544-0088	www.care1st.com
Care1st HP	Medical	(800) 605-2556	www.care1st.com
CCHP	Medicare	(880) 775-7888	www.cchphealthplan.com/
Central HP	Medicare	(866) 314-2427	www.centralhealthplan.com
Easy Choice HP	Medicare	(866) 999-3945	www.easychoicehealthplan.com
Humana HP	Medicare	(800) 457-4708	www.humana.com

Easy Choice online eligibility verification:

https://secure2.ehcsmc.net/ECHP.NET/RemoteMemberEligVerification.aspx

2.3 Other Contact Numbers

Primary Care Providers may also contact the following organizations for additional information.

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

State Department of Health Services: For verification of eligibility for Medicaid patients and managed care members, call the Automated Eligibility Verification Services (AEVS) at (800) 456 2387. A Provider number is required to obtain eligibility information. For claims issues, contact: EDS at (800) 541-5555.

SECTION 3. RESPONSIBILITIES OF IHP PHYSICIANS

3.1 Medical Services Covered under Primary Care Capitation

The following services are covered under the monthly capitation paid to contracted Primary Care Physicians (PCPs) unless special arrangements have been made with IPA. Please refer to your Primary Care Provider Agreement with IPA for more details regarding coverage provisions. Covered Medical Services include all of the services a PCP customarily makes available to patients of his or her practice, including but not limited to the services listed below:

- Maintain office accessibility to members at least 4.5 days per week. All PCPs are required to provide and arrange for 24 hour, 7 days per week on-call coverage for all managed care members unless previous arrangements have been made with IPA
- First point of contact care for persons with previously undifferentiated health concerns
- Office Visits and Examinations (diagnosis treatment of illness and injury);
- Adult health maintenance
- Periodic health appraisal examination, including all routine tests performed in PCP's office
- Routine gynecological examinations including pap smears
- Venipuncture and administration of injections and injectables
- Minor office surgical procedures, including repair of simple lacerations to areas other than the face, ear lavage, I&D of superficial soft tissue abscess, EKG, visual acuity testing, trigger point injections, arthrocentesis, etc.
- Specimen collection
- Nutritional counseling
- Interpretation of laboratory results
- Miscellaneous supplies related to treatment in PCP's Office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies)
- Telephone consultations
- Well-Child Care, including screening and testing for vision and hearing;
- Coordination of other health care services as they relate to a Plan Member's 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 listed services are generally considered primary care services. The PCP must have received appropriate training, within the limitations of scope of practice, and consistent with State and Federal rules and regulations. These guidelines are based on routine uncomplicated cases where care is ordinarily provided by a PCP. This list only provides guidelines, is not intended to be all inclusive, and should be used with clinical discretion.

Allergy	
• 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 home (SBGM) testing • Medication management • Manage DKA • Manage thyroid nodules (testing, scans, ultrasound)	• 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 2 medications for a minimum of 6 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

Gynecology / OB	
• Perform routine pelvic exams and PAP smears • Perform lab testing for sexually transmitted diseases • Wet mounts • Diagnose and treat vaginitis and sexually transmitted diseases • 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 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 myofacial 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 funduscopy 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	
• 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

(*) Only for Medi-Cal Managed Care, this is a "carve-out" service and PCP is only responsible for H&P for patients/members before inpatient mental health admissions and for assessment and referral to County Mental Health Department for outpatient mental health services.

(*) For some Medicare Advantage/Medi-Medi HMOs, this is a "carve-out" service and PCP should refer to these HMOs for Mental Health Network for all services.

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 / Nephrology	
• Diagnose and treat initial and recurrent urinary tract infections • 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 peritesticular 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)

3.2 Role of Specialty Care Physician

Specialty care physicians provide referral services consistent with industry standard medical practices, to IPA members upon request by the PCP with authorization from the IPA. The Specialist is responsible for communicating results and findings back to the member's PCP for continuity and/or coordination of care. The Specialist is responsible for the following:

- Provide IPA authorized medically necessary specialty care
- Work in conjunction with PCP to assure continuity of patient care
- Specialist will make authorization requests through the referring PCP
- Submit treatment plans to PCP and IPA for continued specialty care
- Assist PCP/IPA in coordinating ancillary services and hospitalization

- Arrange for practice coverage by another IPA contracted/participating physician for times or extended periods Specialist is unavailable (i.e. vacation, jury duty, holidays, illness, etc.)
- Provide and arrange for 24 hour, 7 days per week on-call coverage for all managed care members
- 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.

IPA must be notified to arrange for a Memorandum of Understanding to be in place if a non-participating physician is scheduled to take calls for you or assist you with a service or procedure. 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 Primary Care Physicians as required by Health Plan, CMS and/or other regulatory agencies including the State Department of Health Services (SDHS) and the Department of Managed Health Care (DHMC)

Type of Appointment and Services	Access Standards and Requirements
Availability of the PCP	• PCP must be available by telephone 24-hours per day/ seven days per week. • 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 IPA
Appointment Systems	• Providers should use an efficient and effective written or computerized appointment making system, which includes follow-up on broken appointment.
Waiting Time in the Office	• The waiting time for scheduled appointments must be 30 minutes or less.
Appointments for Urgent and Routine Primary Care Services	• For **urgent primary care services**, PCPs are required to triage and provide **same-day appointment** for his/her members. • For Routine primary care services, the timeline for appointments is as follows: 1. For physical exam and routine preventive services – 4 work weeks. 2. Routine ambulatory visits – 7 business days maximum for an appointment.
Appointments for Routine Physician Consultation and Specialty Referral	• Specialist physicians are expected to schedule an appointment for a non-urgent, properly authorized referral within 10 business days.

Type of Appointment and Services	Access Standards and Requirements
Appointment for Routine Prenatal Care	• Initial appointments must be available to members within one week from member request for members in their 1st/2nd trimester • Initial appointments must be made within 3 days of request for members in their 3rd trimester or identified as 'high risk'.
90 day Initial Health Assessment (IHA)	• Each newly enrolled MA member is expected to receive an IHA within 90 days of enrollment. • Use of the age-specific "Staying Healthy Assessment" tool is acceptable and must be completed at the time of the IHA
"Staying Healthy Assessment"	• For members currently enrolled with the PCP, the age-specific tool should be completed during routine physical exam or when a member enters another age group.
Appointment for Sensitive Services	• Sensitive services must be made available to members within two days from request for appointment. • Sensitive services are: Sexual assault, Drug or alcohol abuse, Pregnancy/Family Planning and sexually transmitted diseases • These services will be provided under the following conditions: 1. Without necessity of preauthorization, referral, or parental consent for minors 12 years of age and older. 2. Confidentially, in a manner that respects the privacy and dignity of the individual

3.4 Telephone Access

PCP or office staff must return any non-urgent phone calls within 24 hours to members. Urgent and emergent calls are to be handled by the primary care physician, immediately, 24 hours a day, 7 days a week unless other arrangements have been made with IPA.

3.5 Services for Members with Disabilities

Primary and Specialty Care Physicians must comply with all the provisions of the Americans with Disabilities Act including: A handicapped bathroom or alternative access which is equipped with handrails in the bathroom, handicapped access ramp, handicapped water fountain or alternative provisions, an elevator, when applicable, and at least one handicapped parking space.

TDD/TTY Access for the Hearing Impaired

California State TDD line is 1 (800) 735-2922 and is available to all California residents

3.6 Interpretive Services

- Primary and Specialty Care Physicians are required to offer interpretive services to member in order to provide quality health care services
- If a member declines the interpretive services, the provider must note this in the member's medical records

- IPA providers are expected to provide interpretive services 24 hours a day through their AT&T or other contracted language lines, which providers can access if requested by the member in his/her language.

If a patient has limited English and requires language assistance, contact the appropriate health plan at the number listed above.

3.7 Credentialing and Facility Site Review

IPA contracted providers are required to be credentialed in accordance with guidelines set forth in IPA's Credentialing Policies and Procedures and as required by other applicable regulatory agencies or accrediting bodies. Acceptance of a provider into IPA is contingent upon successfully completing the credentialing process. Additionally, Primary Care Physicians participating in Medi Cal and/or Medicare/Medi-Medi managed care must pass facility site reviews conducted by oversight Plan. Continued participation with IPA is dependent upon successfully completing the re credentialing process that takes place every three (3) years.

The following documents are required for the initial credentialing process:

- Completed California Participating Physician Application
- Copy of current California Medical License
- Copy of current DEA Certificate
- Copy of current Liability Insurance Policy
- Curriculum Vitae
- Copy of Board Certificate (if applicable)
- Hospital Affiliation
- SNP Model of Training (Medicare SNP providers only)

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

- Member complaints
- Information from quality improvement activities
- Member satisfaction

A. Provider Status Change

The State Department of Health Services and CMS mandates 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 IHP (Refer to Provider Change Notification Form in the Forms Section of this Manual)

B. Required Reporting

IPA must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank within 15 calendar days after the effective date of the action, if any of the following events occurs:

- The provider's application for IPA 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 IPA
- IPA participation status changes following notice of any impending investigation based on information indicating medical disciplinary cause or reason.

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

3.8 Hospital Admissions and Admitting Staff

IPA Primary Care Physicians should have admitting privileges to at least one of the contracted hospitals. The Admitting Team should always be notified by the PCP for assistance and coordination of care whenever IPA member needs to be admitted. Refer to IHHMG and IPA Medical Director for notification and follow-up.

3.9 Initial Health Assessments (IHA)

The CMS Medicare Advantage requires an IHA to be performed on all assigned Medicare members within 90 to 120 days of the effective date of enrollment. The "Staying Healthy Assessment" tool can be utilized by PCPs as an IHA for Medicare Advantage members. The tool consists of five age appropriate risk assessments. Each assessment has accompanying education pieces to be used to educate members on various topics, for example: home safety nutrition, injury prevention, etc.

The IHA will help PCPs identify patients in need of health education, counseling, and other medical and social services. The PCP is responsible for the following:

- Assessing whether the member has had a complete physical exam in the last year. If the member has had a physical exam by another physician, the member should sign a medical records release to request the exam and incorporate into the member's chart.
- Documenting all findings into the medical record.
- Performing the Staying Healthy Individual Health Education Behavioral Assessment. The goal of the assessment is to identify high risk behaviors of individual members, prioritize individual health education needs related to lifestyle, environment, and cultural linguistic background, and to initiate and document focused health education intervention referral and follow up (See Section 12 for age specific Assessment forms).
- Administering the appropriate Staying Healthy Individual Health Education Behavioral Assessment to all new members and to all existing members who present for a scheduled visit. The Assessment is age specific and must be administered at the next preventative health visit after the next age plateau is reached. A copy of the age specific assessment tool is provided to the PCPs by the health plans.

Unless deemed inappropriate by the physician, or refused by the member, health assessments should include:

- Health and developmental history
- Unclothed physical examination, including assessment of physical growth
- Assessment of nutritional status
- Inspection of ears, nose, mouth, throat, teeth and gums
- Vision screening
- Tuberculin testing and laboratory tests appropriate to age and sex, including test for anemia, diabetes, and urinary tract infections

- Blood lead testing
- Testing for sickle cell trait where appropriate
- Immunizations appropriate to age and health history necessary to make status current
- Anticipatory guidance and health education appropriate to age and health status, including harmful effects of the use of tobacco products and exposure to second hand smoke

Please Note: If the member refuses to give this information, this should be documented in the medical record.

3.10 Medical Records

The Primary Care Physician is responsible for maintaining a legible, detailed, confidentially stored, easily retrievable medical record for each patient for ten (10) years, as required and mandated by Centers for Medicare and Medicare (CMS). The medical record of a patient is a confidential document used by the physician to maintain a systematic record of the patient's continuing medical care.

Release of medical information and records will be in accordance with Federal, State and local statutes. (Refer to the Forms Section for the Medical Record Release Form)

A. Confidentiality

Medical records will be stored in an area of the medical practice, with access limited to authorized staff only. All staff members must sign a Confidentiality Statement that assures that the 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 any part thereof.

All patient information is confidential and must be protected from disclosure to unauthorized personnel in accordance to 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 Medi Cal 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 indicated in writing
- All pages in the medical record must contain the patient name or identification number.
- All entries are dated and signed by the author. Full signature and title is required.
- All entries must be dated and signed or initialed by the Provider

- The medical record must be legible to others besides the provider and their staff.

C. Notation Requirement

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

- Date of the visit
- Chief complaint
- A documented physical exam relevant to the complaint
- Diagnosis / Impression
- Medication list includes medication history as well as current medications
- Medication allergies, adverse reactions, or the absence of known allergies are noted in a consistent fashion
- Problem list includes medical conditions and significant illnesses and surgeries
- A comprehensive health history is documented 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 which must document:
    - Height, weight, vital signs
    - Chief complaint and unresolved problems from previous visits
    - Physical exam consistent with chief complaint
    - Working diagnosis
    - Tests, referrals, consult, and 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
    - 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 are to be documented in the medical record

3.11 Vaccine and Immunization Administration

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

SECTION 4. ENCOUNTER DATA AND CLAIMS SUBMISSION

4.1 Encounter Data Submission

Encounter data is used to report medical services for patients under capitated contracts. The encounter data is very similar to the information submitted on a fee for service form, but no service related reimbursement occurs. Encounter data must be submitted weekly and on a CMS 1500, when applicable, a PM160 INF or where applicable, UB92. Health Plans imposes significant financial penalties for lack, or inadequate submission, of Encounter data.

4.2 Claims Submission

Industry standards require that all claims be submitted within 60 calendar days 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 as promulgated by the CMS Medicare Program. Claims should be submitted to IPA for those services that are performed by the physician that are not covered under capitation and/or according to the contract. The IPA will only accept claims submitted on an industry standard CMS 1500 or UB92 Claim Form.

In order for the IPA to accurately adjudicate claims and ensure timely processing and payment for services rendered to IPA members, it is imperative that all the required information on the CMS 1500 is provided. All claims submitted will be reviewed to ensure that the billed level of care is consistent with level of care authorized by IPA and/or service level of care provided by provider with proper documentations. In the event a higher level of care is billed, IHHMG will pay based on authorized level of care.

For a complete submission, the following minimum information must be on all CMS 1500 claims to be considered a "clean claim" or encounter data submissions*, 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 9 Code and Diagnosis and Procedure and modifier code(s) (CPT or HCPCS)* - ALL PERTINENT ICD-9 AND CPT CODES PERFORMED DURING EACH VISIT
- Referring physician
- Date of service, place of service, type of service, quantity/unit of service(s), and normal charges*)*
- Authorization Number in Box 23 of CMS-HCFA 1500 Form (when required)
- The Physician's Federal Tax ID number, Medi-Cal or Medicare Provider number, UPIN number (where applicable)*
- Name and address of facility where services were rendered
- Name, address, zip code and phone number of Physician submitter*
- Attached OR 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
- EOMB or EOB attached if other coverage (COB) applies

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

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP
CLAIMS DEPARTMENT
PO Box 60075
Pasadena, CA 91116-6075

Or Providers can sign up on Office Ally website: www.officeally.com or Call: (866) 575-4120

IMPERIAL HEALTH PAYOR CODE IS: **IHHMG**

Please refer to the Compensation Fee Schedule of your Provider Agreement to determine the payment amount the provider may be expected to receive for his/her service(s)s rendered. All payable claims shall be processed in accordance to the fee schedule and guidelines promulgated by each government program. Medicare Advantage HMO claims shall adhere to the prevailing Medicare Fee Schedule and Claims Processing and Payment Guidelines as established by CMS.

For ENCOUNTER DATA submissions, they must be submitted on either LEGIBLE superbills with complete information, or on a CMS (HCFA) 1500 Form. Send ALL encounter date to the following address:

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP
ENCOUNTER DATA DEPARTMENT
PO Box 60075
Pasadena, CA 91116-6075

IHHMG prefers that providers submit encounter data electronically. The management company will provide training on electronic authorization and encounter data entry upon orientation.

Special services that cannot be identified with the appropriate CPT or HCPCS codes shall undergo IPA medical review and, if allowable, will be processed at industry standard norms.

For the Medicare Fee Schedule, providers may access the internet website at:

http://www.cms.gov/Medicare/Medicare.html

(Refer to Section 10.3 for information regarding claim disputes)

SECTION 5. ENROLLMENT AND ELIGIBILITY

5.1 Eligibility Verification

Patient eligibility must be verified before providing any service. Possession of a membership card DOES NOT guarantee eligibility.

- Providers are encouraged to check eligibility of Medicare members by calling IHHMG or the Health Plan directly.
- Always try to find the member's name on the most recent IPA Eligibility List (E List). The E List will be mailed to your office on a monthly basis.

Reminder: Balance billing of any HMO member who is eligible at the time of service is expressly prohibited by state regulations, the HMOs, as well as the IPA.

5.2 Eligibility List (Refer to the Eligibility Verification Form)

The Eligibility list provides monthly information on member enrollment for each Health Plan for every product line (i.e. Medicare Advantage, Medi Cal and/or Healthy Families).

5.3 Capitation Report

The Capitation Report provides monthly information on capitation payment for each member. Capitation is mailed out to providers approximately 10 working days from receipt of capitation payment from the contracted health plan.

5.4 Member Disenrollment

For Medicare Advantage members, the member is locked into the Plan of choice for a period of 12 months, after open enrollment occurs.

Medicare Advantage Medi-Medi members, have the option to change Plans on a month to month basis. PCPs are encouraged to maintain members to promote continuity of care.

5.5 Provider Status Change (Refer to Provider Status Change Form)

Any planned change in status such as an address or phone number change, malpractice insurance coverage or staffing changes, must be reported immediately, and at least ninety (90) days prior to the change, to the Credentialing Department at IHHMG.

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 for Referral Authorization Forms).

Specific Specialty physician services are covered only if they are properly authorized. The authorization requests should be initiated by the Primary Care Provider for the initial referral, or by the specialist for follow-up services with the same specialist. If the patient requires a specialist to specialist referral (for example: an orthopedist wants to refer a patient to a neurologist), the patient must be referred back to the Primary Care Physician. PCPs should use a Specialist Provider within Imperial Health Holdings Medical Group panel. Fax authorization request forms to:

Imperial Health Holdings Medical Group
Attn: Utilization Management Department
Phone No.: (626) 838-5100 Ext 1
Fax No.: (626) 364-0329

In accordance with National Committee on Quality Assurance (NCQA) standards, UM staff if IHHMG and Medical Directors who make or supervise utilization related decisions base these decisions only on the clinical appropriateness of care and service.

Imperial Health Holdings Medical Group 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 Health holding medical group does not encourage decisions that result in underutilization.

6.2 Sensitive Services [FOR MEDI-CAL MEMBERS ONLY]

Patients do not require an authorization for self-referring to a provider of their choice within the network for the following sensitive services:

- Family Planning
- Communicable Diseases, STDs
- HIV testing and counseling

Provider is responsible for referring patients to an IPA contracted specialist. All referrals for spine, pelvis, head and femur fractures for patients under 21 years of age will require authorization as these conditions may qualify for CCS coverage.

6.3 Approval Process for Routine Referrals

- For Medicare Advantage members, allow 14 calendar days for authorization of non emergent referrals.
- Use the IPA Referral Forms provided
- In order to avoid unnecessary delays, the following information must be provided:
    - Member's Name
    - Member ID Number
    - Specialist Name
    - Reason for referral (provide all pertinent progress notes which may include diagnostic test results, medications or treatments tried)
    - Number of visits requested

- CPT and ICD9 codes

Fax authorization form to IPA Utilization Management Department at (626) 364-0329.

For guidelines on authorization turn-around time for each type of insurance/coverage, please refer to www.iceforhealth.org or contact the UM Department.

6.4 Approved Referrals

Once a referral request is approved, the IPA Utilization Management Department will notify the PCP, the patient/member and the Specialist of the approval.

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

It is the responsibility of the PCP to track and record the member having kept the appointment with the specialist, date and time.

6.5 Denied Referrals

IPA's UM department will mail a letter to the patient and the provider informing them of any denial. The letter contains information on the Appeal Process.

A copy of the Denial Letter is sent to the PCP. Attached to the letter is the medical policy criterion for the denial. This letter should be filed in the member's medical record.

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

- Member is not eligible with IPA
- Service requested is not a covered benefit
- Service requested is the responsibility of the Primary Care Provider
- Medical necessity could not be established

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 PCP. The missing information may be:

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

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

6.6 Emergency Room Utilization, Urgent Care and Emergent Referrals

Emergent is defined as 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 patient.

The Primary Care Physician or his/her on call physician is responsible for determining the medical necessity of an Urgent Care or Emergency Room visit. After hours, Urgent Care Referrals should be directed to the contracted Urgent Care Centers (listed on Provider Rosters):

The Emergency Room MUST NOT be utilized in lieu of the Primary Care Physician's office. Only true medical emergencies should be referred to the Emergency Room.

- The Primary Care Physician is responsible for immediately responding to all calls from the emergency room.

- The patient will receive a medical screening exam (MSE) in the Emergency Room.
- The PCP should evaluate the situation and give the specific orders to the 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 EMERGENCY ROOM.
- If the patient requires additional treatment the PCP must be contacted.
- For an inpatient admission, the ER staff should obtain an authorization from the PCP. If PCP does not have admitting privileges at the hospital, the Admitting Physician should be called.

Procedure for Emergent Referrals

1. Make sure the Referral Form contains the following information: Member's name, reason for referral, Member ID number, number of visits requested, specialist name, CPT and ICD9 codes

2. Fax a copy of the Authorization Referral Form to IPA UM Department at (626) 364-0329. Requests may also be phoned in.

3. The Utilization Management Department will review for eligibility, benefit coverage and medical necessity.

4. PCP and Specialist will receive a copy of the authorization 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 Primary Care Physician is responsible for notifying IPA UM Department via fax at (626) 364-0329 or via phone at (626) 838-5100, of any emergency room visit or emergency inpatient admission by the following business day.

In the event the PCP is unaware of an inpatient admission; the UM department will notify the PCP as soon as the information comes forward.

SECTION 7. NON COVERED PROGRAM SERVICES

7.1 Non covered Medicare Advantage and/or Medicaid 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 IPA (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 Health Plan
- Services rendered prior to beginning date as a member of IPA or following termination of coverage
- Hospital or Medical services that are not medically necessary
- Cosmetic Surgery (Breast reconstruction is a covered benefit if following mastectomy or catastrophic disfiguring trauma)
- Experimental Services
- Infertility treatment (Refer to Plan Member's EOC for limitations)
- Unauthorized ambulance transportation for a non emergency situation

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

7.2 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 8. LINKED AND CARVED OUT MEDICARE SERVICES

Below are some of the examples of services that are linked or carved out of the members Health Plan benefits, Medicare, or the Medi-Cal Programs. IPA and Plan will help coordinate these services with the provider and the appropriate public health agency.

For Medicare Advantage, Managed Care Program:

- Adult Day Health Care Services
- Custodial Care (Medi-Medi Managed Care shall defer to member's Medi-Cal Plan)
- Dental Services
- Optometry Benefits
- Prescription Drugs – Medicare Part D

SECTION 9. MEMBER HEALTH EDUCATION

9.1 Provision of Health Education Materials

All affiliated Health Care Providers are responsible for providing and/or arranging for Culturally and Linguistically appropriate health education, prevention and counseling services to Medicare managed care members, and to encourage members to take increased responsibility for their personal health. Imperial Health Holdings Medical Group can assist you with any brochures, documentation, or related information in many languages and for various health topics. Please contact our Cultural and Linguistics Representative through for more information on how to obtain materials. (See Section 2.1 Imperial Health Holdings Medical Group Phone Numbers)

9.2 Documentation of Health Education in Medical Records

Documentation of health education provided to managed care members in medical records should include:

- Date
- Health education relative to the diagnosis and/or presenting problem
- Any support materials given to or presented to the Patient (e.g., "patient viewed asthma video" or "patient given brochure on diabetes.")
- Patient's understanding of the education provided
- Any follow up needed or that is appropriate (e.g., completed referral form, attended class, re visit scheduled)
- Referral to health education services
- Signature and title of all staff providing health education
- Health education activity rendered (e.g., one on one consultation, class, support group session)
- Health education resources provided (e.g., brochure, newsletter, videotape, audiotape)

9.3 Health Education Topics

There are many resources that provide health education materials on the following topics that are mandated by the State Department of Health Services:

- Anticipatory Guidance
- Asthma
- Dental Health
- Diabetes
- Exercise
- HIV / STD
- Injury Prevention
- Lead Poisoning
- Nutrition*
- Substance Abuse
- Tobacco Prevention/Cessation
- Tuberculosis

IPA also has health education materials available. We will provide them for your Medicare or Medi Cal members upon request. (Please refer to the Health Education Referral Form in the Forms Section, Section 14 of this manual.)

9.4 Advance Directives

An Advance Directive is a formal document, written in advance of an incapacitating illness or injury in which once can assign decision making for future medical treatment. California legally recognizes the Durable Power of Attorney for Health Care (DPAHC) as 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. 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 forgoing of life sustaining procedures.
3. The PCP may assist members who have questions about an Advance Directive; however, he/she may not influence the member in making the decision regarding the member's health care.
4. Documentation in the medical record must be entered when the member has been informed of his/her right to execute an Advance Directive and/or whether the member has actually executed an Advance Directive.
5. When the member executes an Advance Directive, a signed copy must be in the medical record.
6. If the patient 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 subsequently becomes incapable of directing his/her care.

For more information and forms please contact:

The California Medical Association P.O. Box 7690 San Francisco, CA 94120 7690 (415) 882 5175	or	California Health Decisions 500 South Maine St., Suite 400 Orange, CA 92668 (714) 647 4920

IPA will provide a copy of the Advanced Directive Form to the provider upon request.

9.5 CULTURAL & LINGUISTIC REQUIREMENTS AND SERVICES

The Health Education Department of the Health Plan where the patient is a member is responsible for providing and ensuring health education materials and services meet cultural and linguistic standards as well as material topic requirements. Materials and services are available to members in English and Spanish and some in other languages including Vietnamese.

Interpreter Services at Provider Site

- Providers are required to offer interpretive services to a member if necessary in order to provide quality services.
- Providers also must post a sign indicating the availability of interpreter services.

- Members are not required to use family members or friends as interpreters.
- Contracted providers should not require nor suggest the Limited English Proficient (LEP) members provide their own interpreters. 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 beneficiaries to reveal personal information critical to their situations.

SECTION 10. COMPLAINTS AND GRIEVANCES

10.1 Member Complaints and Grievances

The complaint and grievance process applies when a member or provider 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 the health plans
- Members may be directed to call the Health Plans' Member Services Department to file a grievance.
- Members can obtain a complaint form, either from their provider's office, or the PHC (Refer to the Forms Section for a copy of the grievance form)
- IPA and/or Health Plan are required to acknowledge a member's complaint within five (5) working days and resolve the member's complaint within thirty (30) working days.
- Members can call the Plan and/or the Department of Managed Health Care (DMHC), if the complaint is not resolved to their satisfaction.

Most common grievances result from:

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

10.2 Physician Complaints

Physicians and other health care providers are encouraged to aid in the overall quality improvement efforts of the provider network by bringing forth issues that affect member's care, operational issues, or other service problems.

- Physicians and other health care providers with provider issues can submit a grievance to the IPA by telephone, fax or letter.
- Quality Management staff will assist in resolving the issue and will forward the complaint or problem to the health plans.
- Physicians 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 5 business days. Providers will receive written confirmation of the outcome of the grievance.

10.3 Claims Settlement & Grievance Practices

Provisions under AB1455 provide for fast, fair, and cost effective dispute resolution mechanisms for claim disputes. A claim dispute/grievance will be processed under the IPA's Provider (Claim) Dispute Resolution Policy & Procedure guidelines. Disputes must be submitted in a written format and clearly document and identify the issue at dispute. (Refer to the following "Downstream Provider Notice" for full disclosure and instructions.)

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

10.4 Member and Provider Satisfaction Surveys

In order to measure the overall satisfaction of individual physicians and members IHHMG requests that physicians participate in data collection regarding satisfaction.

Physician Satisfaction are recommended to be completed at least once a year.

Attached forms 13.9 and 13.10 are provided for the purpose of gaining information regarding satisfaction. Form 13.9 is Member Satisfaction form. The IPA asks that Primary Care Physicians give these to members to fill out. Members may fill the form out and return it to the PCP or, if needed, office staff can assist the member in completion.

Form 13.10 is Physician Satisfaction Form. This form is for the PCP to complete.

Both forms should be faxed back to the identified number at the bottom of the form.

SECTION 11. COMPLIANCE

11.1 Code of Conduct and Business Ethics

The Code of Business Conduct is a critical component of a compliance plan. Imperial Health Holdings Medical Group 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
- Continuously Strive to Improve What We Do and How We Do It

11.2 Compliance Program

Imperial Health Holdings Medical Group'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 Health Holdings Medical Group's Compliance Program strives to improve operational quality by fulfilling four primary goals:

- Articulate and Demonstrate Imperial Health Holdings Medical Group'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.
- Create an Environment that Encourages Employees to Recognize and Resolve Potential Compliance Problems.

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

11.3 Fraud, Waste and Abuse Compliance

The purpose of the Imperial Health Holdings Medical Group Fraud and Abuse Awareness and Detection Plan is to comply with Section 1348 of the California Health and Safety Code and other related state and federal laws, to identify and reduce costs to Imperial Health Holdings Medical Group, our 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. This goal includes activities that are detailed in the anti-fraud plan. This includes activities that:

- Protect California health care consumers and particularly Imperial Health Holdings Medical Group members, providers, and Imperial Health Holdings Medical Group itself against potential 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 Health Holdings Medical Group staff to follow if fraud is suspected; and
- Notify the appropriate internal departments, company officers/Board of Directors and/or government agencies.

The Imperial Health Holdings Medical Group 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 Health Holdings Medical Group intranet. A hard copy of these policies and procedures is available to employees and other interested parties through the Imperial Health Holdings Medical Group Administrative Offices. Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid 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 Health Holdings Medical Group has established a Fraud and Abuse Compliance Hotline (hereinafter "Hotline"), which is available to all employees and Members 24 hours per day, 7 days per week. 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 FDRs and their employees.

Employees, members, or any other interested party may call the Hotline to report suspected fraudulent, illegal, or non-compliant behavior affecting Medicare, or any other product line, at Imperial Health Holdings Medical Group. Imperial Health Holdings Medical Group 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 in the course of the investigation. The hotline telephone number is (800) 497-5509. Imperial Health Holdings Medical Group has also implemented a hotline email address, Compliance@imperialhealthholdings.com

Members, Imperial Health Holdings Medical Group employees, providers or any other person who feel 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.

11.4 HIPAA Privacy practice notice guidelines

A. Background

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

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

B. Federal Requirements

Standards for Privacy of Individually Identifiable Health Information

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

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

In general, the content of the notice must contain:

1. A header "THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO 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 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; raise funds for the covered entity, 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
    - the right to obtain a paper copy of the notice upon request as provided in 164.520
7. A statement that the covered entity is required by law to maintain the privacy of protected health information and to provide individuals with a notice of its legal duties and privacy practices with respect to protected health information.
8. A statement that the covered entity is required to abide by the terms of the notice currently in effect.
9. A statement that the covered entity reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.
10. A statement describing how it will provide individuals with a revised notice.
11. A statement that individuals may complain to the covered entity and to the Secretary of Health and Human Services if they believe their privacy rights have been violated; a brief description as

to how one files a complaint with the covered entity; and a statement that the individual will not be retaliated against for filing a complaint.

12. The name or title, and telephone number of a person or office to contact for further information.
13. An effective date, which may not be earlier than the date on which the notice is printed or otherwise published.

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

SECTION 12. Quality Management Program

Purpose

IHHMG 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.

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

Scope

The scope of IHHMG 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 including credentialing, quality improvement, utilization management, member safety, complex case management, disease management, complaints, grievances and appeals, customer service, provider network, claims payment, and information system

The QM Program addresses:

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

- Member complaints, grievances, and appeals research / feedback from the Health Plans
- Provider availability and access / timeliness report results from the Health Plans that includes:
    - IHHMG maintains an adequate network of primary, and specialty care practitioners and routinely monitors how effectively the network meets the needs and preferences of its membership
    - Access / Timeliness standards
        - Regular or routine care appointment = within 15 days
        - Urgent care appointment = within 48 hours
        - After-hours call by the practitioner to the member = within 30 minutes

        - 90% of members report that they 'always' or 'usually' get an appointment for health care at a doctor's office or clinic as soon as they need it.
        - 90% of members report that they 'always' or 'usually' get a follow-up of routine appointment as soon as they need it.
- Coordination of Care / Transitions of Care
- Preventative Health
- Member experience with healthcare services provided
- Provider experience with Utilization Management
- Medical record audit results

Goals and Objectives

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

- Develop and maintain an ongoing monitoring system to detect problems of quality of care or service with individuals or systems encountered by members
- Develop, implement, and evaluate corrective action plans when deficiencies have been identified
- Identify, implement and assess quality improvement initiatives in the areas of quality of care, service and member safety
- Incorporate internal and external regulatory standards related to quality improvement activities
- Utilize results from practitioner performance issues which are obtained from a variety of sources:
    - Quality of care and service issues reported during the appeal and grievance process investigation
    - Quality indicators, and audit/survey studies conducted throughout the year for credentialing, recredentialing and contracting of health care providers and facilities
- Design and maintain a QM process that supports continuous quality improvement using the cyclical methodology of planning, doing, studying, and acting
- Preventive Health
- Collaborates with health plans in the completion of health appraisals for IHHMG members. This gives members the opportunity to engage actively in managing their own health care by encouraging members 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
- Use the health plans' data to analyze the effectiveness of the DM program to IHHMG members. 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 the Health Plan 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 RNs / LVN’s that make UM decisions, at least annually.

- Ensure QM activities are linked and coordinated with other services including utilization management, claims, credentialing and recredentialing
- Evaluate annually the effectiveness of the previous year's QM program, activities and interventions
- Train staff with required QI activities, as needed

Strategy

The planning and implementation of annual QM Program activities follows an established process and includes 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 IHHMG. 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, respectively.

Quality Improvement Initiatives

The following are the current IHHMG Quality Improvement Activities (Health Plan and / or IHHMG initiated) that measure and monitor access to care:

- Appointment Availability Studies
- Initial Health Assessment monitoring

The following are the current IHHMG Quality Studies (Health Plan and / or IHHMG initiated) that measure and monitor provider and Member experience:

- Consumer Assessment of Health Care Providers and Systems (CAHPS)
- Provider Experience Survey
- Member Grievance Review
- Member experience surveys

The following are the current IHHMG Quality Studies (Health Plan and / or IHHMG initiated) that evaluate preventive and chronic care, as well as coordination, collaboration, and patient safety:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Coordination of Care Studies
- Patient Safety Studies

The following are the current IHHMG Quality Studies (Health Plan and / or IHHMG initiated) that evaluate appropriate care for Members with complex medical needs:

- Complex case management annual evaluation
- Disease specific quality studies

The following are the current IHHMG Quality Studies (Health Plan and / or IHHMG initiated) that evaluate our ability to serve a culturally and linguistically diverse membership:

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

Measurement Process

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

Communication and Feedback

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

- Providers are educated regarding quality improvement initiatives through on-site quality visits, provider newsletter, specific mailings, and the IHHMG website.
- Specific performance feedback regarding actions or data is communicated to providers.
- General and measure-specific performance feedbacks are shared via special mailings, provider newsletter, and the IHHMG website.
- Feedback may include, but is not limited to:
    - Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements. o Performance indicators are also used to identify quality issues. When identified, IHHMG QM staff investigates cases and determines the appropriate corrective action plans (CAP). IHHMG Subcommittees review cases involving patient safety and quality of care issues, and recommends 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 IPA; de-delegation of specified functions; termination of participation or non-renewal of the Agreement with IHHMG.

Annual Evaluation and Update of the QM Program

On an annual basis IHHMG evaluates the effectiveness and progress of the QM Program and

Work Plan with 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, time lines, methodologies used, and follow-up mechanisms is reviewed by QM staff and the Chief Medical Officer (CMO).

- The report includes pertinent results from QM Program studies, patient access to care, IHHMG 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

IHHMG performs a series of activities to monitor IPAs and other delegated entities.

For IPA 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
- Provider Satisfaction Surveys

Enforcement/Compliance

The QMC is responsible for monitoring and oversight of the QM Program including enforcement of compliance with IHHMG standards and required activities. Activities can be found in Policies & Procedures related delegated oversight, **when there is delegation** and Provider Manual for IPA provider / provider offices.

The general process for obtaining compliance when deficiencies are noted, are Corrective Action Plans (CAP) are requested and followed up to ensure compliance.

Authority and Responsibilities

Board of Directors

Through the QMC, the Board of Directors (BOD) has the ultimate responsibility and authority for the quality of care and service delivered by member providers. The BOD reviews and approves the QM Program and the QM Work Plan on an annual basis.

Chief Executive Officer

IHHMG'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 IHHMG Board of Directors.

Chief Medical Officer

The Chief Medical Officer (CMO) for IHHMG is responsible for the daily oversight of QM activities. The CMO reports to the CEO of IHHMG

Medical Management Manager

Works in concert with and under guidance from the CMO

Directs, coordinates and manages ongoing daily activities of the QM Program.

Plans, organizes and implements quality improvement projects throughout the network.

Ensures the QM Program complies with health plan, state, federal and regulatory standards. The Medical Management Manager reports directly to IHHMG's CMO.

QMC Structure

The **QMC** reports directly to the Board of Directors. The QMC has primary responsibility for overseeing the 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 that implemented plans are effective.

The Committee is interdisciplinary, with membership appointed by the BOD in accordance with the bylaws. Operation of the Committee is by simple majority. No committee member shall vote on any case in which he/she is personally involved. An IHHMG physician appointed by the BOD chairs the Committee. 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 Committee includes consistent meeting attendance, involvement in discussions of agenda items, analyzing results, and assisting in follow-up and problem resolution.

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

IHHMG non physician employees are non-voting participants.

Health Plan Medical Directors 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 requiring immediate action will be taken directly to the IHHMG Chief Medical Officer 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 the IHHMG Chief Medical Officer or designee, report findings and recommendations to the QMC. The Subcommittees meet quarterly or more frequently if necessary.

Peer Review

The Peer Review Subcommittee is responsible for peer review activities for IHHMG.

Role – The Peer Review Subcommittee reviews Provider, Member or Practitioner grievances and/or appeals received from the Health Plans, practitioner related quality issues and other peer review matters.

Structure

The Peer Review Subcommittee is composed of IPA 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 Peer Review Subcommittee serves as the committee for clinical quality review of practitioners, evaluates and makes decisions regarding member or practitioner grievances and clinical quality of care cases referred by the health plans.

Credentialing

The Credentialing Subcommittee performs credentialing functions for practitioners who either directly contract with IHHMG or for those submitted for approval of participation in the IHHMG network by IPAs that have not been delegated credentialing responsibilities.

Role

The Credentialing Subcommittee is responsible for reviewing individual practitioners who directly contract with IHHMG. This subcommittee denies or approves their participation in the IHHMG network.

Structure

The Credentialing Subcommittee is composed of multidisciplinary participating primary care physicians or specialty physician representative of network practitioners. A behavioral health practitioner and any other specialist not represented by committee members, serves on an ad hoc basis for related issues.

Function

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

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

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

Pharmacy and Therapeutics (P&T)

The P&T Subcommittee performs ongoing review and modification of the IHHMG Formulary and related processes and oversight of the pharmacy network including medication prescribing practices by IHHMG providers.

The P&P Subcommittee assesses usage patterns by members and assisting 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 IHHMG practitioners, and under- and overutilization of medications.

Structure

The P&T Subcommittee is composed of clinical pharmacists and 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 P&T Subcommittee serves as the committee 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 ensures that decisions are based only on appropriateness of care and services. The P&T Subcommittee is responsible for developing, reviewing, recommending and directing the distribution of disease state management or treatment guidelines for specific diseases or conditions that are primarily medication related.

Utilization Management (UM)

The UM Subcommittee performs oversight of UM activities conducted by IHHMG and delegated IPAs 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 UM Subcommittee directs the continuous monitoring of all aspects of UM and CM administered to Members.

Structure

The UM Subcommittee is composed of IPA Medical Directors, or designated physicians representative of network practitioners. A behavioral health physician and any other specialist, not represented by committee members, serve on an ad hoc basis for related issues.

Function

The UM Subcommittee reviews and approves the Utilization Management, Care / Case Management, annually. The Subcommittee monitors for over- and under-utilization and ensures that UM decisions are based only on appropriateness of care and service.

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

Behavioral Health Advisory Subcommittee

Behavioral Health is not delegated. If ever, delegated, there will be a subcommittee.

QMC Responsibilities

- Annually review, modify and approve:
    - Evaluation of Previous Year QM Program o QM Program
    - QM Workplan o QM Policies& Procedures
- Review and acceptance of:
    - Preventive health guidelines received from Health Plans
- Ongoing review of o Health Plan reports o Standards for over and under utilization
- Identify opportunities to improve care
- Ensure integration of QM and utilization management 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 Utilization Management Committee and Credentialing Committee.
    - Forwards identified issues to the specific Health Plan
- Evaluates and approves reports sent to the Board of Directors.
- 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 corrective action plans are implemented. It ensures that necessary information is communicated to the relevant providers, departments, or institutions when problems or opportunities to improve care and/or service are identified.
- Identifies findings appropriate for inclusion in provider quality files that are reviewed at the time of Recredentialing. The Committee may choose to send information to the Credentialing committee prior to reappointment, according to its discretion.

QMC Confidentiality Statement

All members of the QMC shall be required to sign a confidentiality statement at least annually. The confidentiality agreement will be kept on file at the offices of IHHMG. All QMC records and proceedings are confidential and protected as provided by Section 1157 of the California Evidence Code, whether or not marked: “Confidential and protected as defined by Section

1157 of the California Evidence Code". Signed minutes are maintained in a locked file at IHHMG offices, available only to authorized persons.

Committee Minutes

QMC minutes and documents may be reviewed by authorized health plan representatives.

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

- 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 of the QMC are kept in a confidential manner at IHHMG's offices. A copy of the approved minutes is forwarded to the following Board of Directors meeting.
- Minutes of the QMC meeting 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
- 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

When QM is Delegated:

Clinical Practice Guidelines

IHHMG develops, periodically reviews and updates Clinical Practice Guidelines that may be used by providers to determine how specific conditions can most effectively and appropriately be prevented, diagnosed, treated and managed.

- IHHMG adopted the following disease conditions for the clinical practice guidelines and which are the clinical basis of the Disease Management programs:
    - Hypertension in Adults with Diabetes
    - Congestive Heart Failure
- Based on the guidelines developed or adopted by the QMC, there is developed of medical criteria and performance measures for the monitoring and evaluation of care provided to members.
    - Guidelines are based upon established national guidelines, where available, scientific literature and prudent practice. Guidelines are peer reviewed and developed by consensus.

- Guidelines are reviewed at least every two years by the QMC and revised if necessary to ensure that they are consistent with current literature and national guidelines as well as the outcomes and experience of the provider network.
- Guidelines are provided to providers as they are developed and/or revised through educational sessions, mailings, newsletters, Website and updates to provider manuals.

Quality Improvement (QI) Delegation Oversight:

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

Pre Delegation Assessment / Evaluation

IHHMG conducts pre-delegation evaluation at least twelve (12) months prior to implementing delegation

Delegation Agreement

When there is QI sub-delegation a delegation agreement is executed outlining the responsibilities and activities of the delegated entity that is delegated to provide QM services.

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

Communication to IPA Providers & Delegates

IHHMG provides the following information to the network provided its delegated entities:

- Member experience data, if delegated by IHHMG or contracted health plan.
- Data from:

o Complaints o CAHPS 5.0 H Survey results o Other data collected on members' experience with the delegate's services. o Clinical performance data.

- HEDIS measures, claims and other clinical data collected by the organization or its contracted health plan if applicable.

Provider Contracting

IHHMG contracts with practitioners and providers specifically require that:

- Practitioners cooperate with QI activities.
- Practitioners maintain the confidentiality of member information and records.
- Practitioners allow the organization to use their performance data for quality improvement activities.
- Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.
- The provider manual or policies are considered as extensions of the contract.

IHHMG 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 the medical record standards and achievement of performance goals.

Audit results with deficiencies found will be reported to the Quality Management Committee, Credentialing Committee and the practitioner. The following are the recommended thresholds and actions required:

Continuity and Coordination of Care / Transitions of Care

IHHMG takes an active role in the facilitation, across transitions and settings. There are policies and procedures that support the providers in continuity and coordination of care across settings or transitions between medical and behavioral health services and between practitioners and providers.

The processes include Medical and Behavioral Health Care with the focus on:

- Members getting the care they need
- Practitioners and providers getting the information they need to provide the care members need

There are policies and procedures that support the providers in continuity and coordination of care across settings or transitions between medical and behavioral health services and between practitioners and providers.

Member Safety

IHHMG continuously monitors patient safety to support practitioners and providers in improving the safety of their practices.

- PCP Office
  This study assesses PCP compliance with IHHMG and Department of Health Care Services (DHCS) standards for patient safety and identifies common areas of deficiency in physical facility accommodations and infection control practices throughout the IHHMG network.

- Inpatient Facilities
  IHHMG considers the quality of care in acute, rehabilitation and skilled nursing facilities to be a top priority. To ensure member safety, IHHMG assesses, tracks, and reviews the following measures:

  o Readmission reports; o One day length of stay reports; o Post OP wound infection referrals o Quality of Care referrals for any adverse outcome related to an inpatient stay.

QM Activities

- Standing annual activities included in the QM Program include: 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).
  - Office Waiting Time audits (e.g. members not waiting more than
    - 30 minutes on the average per provider for their scheduled appointments)
- Review of Health Plan Member Experience Survey results; develop corrective action plans if indicated
- Review of IHHMG Provider Experience Survey; develop corrective action plans if indicated
- Clinical Practice Guidelines development / adoption Ongoing quality of care and case reviews per policy and procedure.

QM Annual Work Plan

- The QM Annual Work Plan is developed and implemented in order 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. o Time frame for completion for each activity. o Monitoring of previously identified changes, issues and corrective actions.
    - Scheduled date for program project and activity re-evaluation.

Coordination Of UM and QM Functions

- The Utilization Management (UM) Program along with the Utilization Management Committee (UMC), with its emphasis on medical service utilization management, and the QM (QM) Program which focuses on the concepts of QM and continuous quality improvement, work in conjunction with each other. IHHMG 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 uses 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 UMC for review. The issues are investigated and reviewed by the respective departments and committees when corrective actions may be recommended. The UM and QMC s provide an environment to ensure that each program is functioning in concert with the other.

QM Process

This 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 are:

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

The **QM process** is integrated across all departments. Key indicators of clinical and service quality that reflect the needs of members, providers, and health plans have been developed. Standards, goals,

guidelines, or benchmarks will be defined for each indicator. Action plans are implemented and monitored to address those areas that fall below the indicated standards.

Annual QM Program Evaluation

The QMC provides an annual evaluation of the effectiveness of the QM Program and Work Plan activities to the Board of Directors. 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.
- The report makes recommendations on future QM activities, Work Plan revisions and changes to the overall Program. The Board of Directors may approve the recommendations and report or may make independent recommendations.

Health Education Program

The purpose of the Health Education Program is to improve the health status of members in a variety of modalities for compliance with **NCQA Standard QI 7**. This may include providing members with preventive health literature, educational classes and wellness programs. The primary objective is to directly involve the members in their own health promotion and health maintenance.

Health education services include classes, individual counseling and support groups.

SECTION 13. PROVIDER AND HOSPITAL ROSTER

13.1 Laboratory

American Bio-Clinical Laboratories (Please see Patient Service Centers Roster)
2730 North Main Street
Los Angeles, CA 90031
Tel: (323) 222-6688
Fax: (323) 222-3388
www.abclab.com

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

13.2 Radiology/Diagnostic Centers

UMI (United Medical Imaging Healthcare, Inc. - Please see area locations listing)

Arcadia Radiology Medical Group - Please see area locations listing)

Madison Radiology - Please see area locations listing)

RADNET/Beverly Radiology Medical Group - Please see area locations listing)

13.3 Contracted Hospital Facilities

IHHMG uses contracted hospital and inpatient facilities (skilled nursing, rehab, etc…) contracted with contracted health plans. The management company will periodically send the list of contracted hospital and facilities for each health plan to primary care providers. If the primary care provider has an immediate need to know the contracted hospital and facilities, please contact the UM department, look on the health plan's website or contact IHHMGs provider services representative.

13.4 PCP and SPECIALISTS ROSTER

See Attached Roster

SECTION 14. FORMS

14.1 Adult Risk Assessment & Health History Enclosed

14.2 Referral Authorization Request Enclosed

14.3 Member Complaint/Grievance Form from Health Plan- Contact respective health plan

14.4 Health Education Referral Form

14.5 Community Resource Guide-Contact respective health plan

14.6 Facility Site Audit Tool Contact respective health plan for pre-audit format (short form FSR available on www.iceforhealth.org)

14.7 Provider Satisfaction Survey Enclosed

14.8 Member Satisfaction Survey (only available if disseminated by contracted health plans)

SECTION 15. MEDICARE ADVANTAGE PROGRAM/MEDICAL

Brand New Day HMO - Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Please refer to the Brand New Day HMO's website, http://brandnewdayhmo.com/

Easy Choice Health Plan (A Wellcare Company) - Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Please refer to the Easy Choice Health Plan website, http://easychoicehealthplan.com/

Central Health Plan of California- Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Please refer to the Central Health Plan website, http://centralhealthplan.com/

Care 1st Health Plan - Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Care 1st Health Plan - Medical
- Summary of Benefits

Please refer to the Care1st Health Plan website, https://www.care1st.com/

Alignment Health Plan - Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Please refer to the Alignment Health Plan website, http://alignmenthealthplan.com/

Humana Health Plan - Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Please refer to the Humana Health Plan website, https://www.humana.com/

Blue Cross - Medical
- Summary of Benefits

Please refer to the Blue Cross website, http://www.bluecrossca.com

Chinese Community Health Plan - Medicare Advantage Plan
- Summary of Benefits
- Prescription Drugs – Part D Q&A

Please refer to the Chinese Community Health Plan website, https://www.cchphealthplan.com/

SECTION 16. AB1455 CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP DOWNSTREAM PROVIDER NOTICE
AB1455 CLAIMS SETTLEMENT PRACTICES &DISPUTE RESOLUTION MECHANISM
As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products and other applicable lines of business where IMPERIAL HEALTH HOLDINGS MEDICAL GROUP is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

16.1 Claim Submission Instructions

A. Sending Claims to IPA

Claims for services provided to members assigned to IPA must be sent to the following:

Via Mail:	PO Box 60075 Pasadena, CA 91116-6075
Via Physical Delivery:	Not currently accepting
Via e-mail:	Not currently accepting
Via Fax:	(866) 720-1012 (Dispute only)
Via Clearinghouse:	N/A

B. Calling IPA Regarding Claims

For claim filing requirements or status inquiries, you may contact IPA @ (626) 838-5100 Option 3

C. Claim Submission Requirements.

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by IPA:

Submission of a Clean Claim within industry standard timelines per line of business with claims not to exceed 90 calendar days;

Submission of information and documentation upon request by IPA subject to Title 28 CCR 1300.71(a)(10)

D. Claim Receipt Verification.

For verification of claim receipt by IPA, please Contact Claims @ (626) 838-5100 Option 3, or Via E-Mail at: claims@imperialhealthholdings.com

16.2 Claims Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute.

A contracted provider dispute is a provider's written notice to IPA and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially

similar multiple claims that are individually numbered) that has been denied, adjusted or contested, or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. Sending a Contracted Provider Dispute to IPA

Contracted provider disputes submitted to IPA must include the information listed in Section II.A, above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of: Provider Relations and Manager of Utilization and Quality Management at:

Via Mail:	600 S Lake Ave Suite 308 Pasadena, CA 91106
Via Physical Delivery:	Not currently accepted
Via e-mail:	Not currently accepted
Via Fax:	(866) 876-1520

Time Period for Submission of Provider Disputes regarding Claims
Contracted provider disputes must be received by IPA within 365 days from provider's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or

In the case of inaction, contracted provider disputes must be received by IPA within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted provider disputes that do not include all required information as set forth above in Section 15.2.A may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to IPA within thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes. IPA will acknowledge receipt of all contracted provider disputes as follows:

- Electronic (computerized format not currently available) contracted provider disputes will be acknowledged by IPA within two (2) Working Days of the Date of Receipt by IPA.

- Paper contracted provider disputes will be acknowledged by IPA within fifteen (15) Working Days of the Date of Receipt by IPA.

Contacting IPA Regarding Contracted Provider Disputes.
All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to IPA at: (626) 838-5100

Instructions for Filing Substantially Similar Contracted Provider Disputes.
Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

- Sort provider disputes by similar issue
- Provide cover sheet for each batch
- Number each cover sheet
- Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheet

Time Period for Resolution and Written Determination of Contracted Provider Dispute.

- IPA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments.

- If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, IPA will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

16.3 DISPUTE RESOLUTION PROCESS FOR NON-CONTRACTED PROVIDERS

Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to IPA challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in section 15 - 2.B, 2.C, 2.D, 2.E, 2.F, 2.G, and 2.H above.

16.4 Claims Overpayments

A. Notice of Overpayment of a Claim

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

B. Contested Notice

If the provider contests IPA'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 IPA stating the basis upon which the provider believes that the claim was not overpaid. IPA will process the contested notice in accordance with IPA's contracted provider dispute resolution process described in Section 15.2 above.

C. No Contest

If the provider does not contest IPA's notice of overpayment of a claim, the provider must reimburse IPA within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to Payments

IPA may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse IPA within the timeframe set forth in Section 15.4.C., above, and/or (ii) IPA's contract with the provider specifically authorizes IPA 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, IPA will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim(s)

16.5 Effective Date

Pursuant to the terms promulgated under AB1455, this notice will be deemed effective for implementation as of January 1, 2004.

SECTION 17. OFFICE ALLY & ONLINE SERVICES

Web Portal, IPA Website Please visit our websites to verify eligibility, submit claims, authorization submission, and inquiry status information. Providers can also take advantage of our on-line service to download a copy of the primary care physician and specialist provider rosters. You can also search individually for a PCP, specialist, and ancillary provider.

Our on-line features:

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

To setup an account with Imperial Health Holdings Medical Group web portal, contact us at

phone at (626) 838-5100

Office Ally Providers are encouraged to setup an account to start submitting all claims through Office Ally. Imperial Health Holdings Medical Group has opted to partner with Office Ally for all claims submissions.

Please note our payer's ID is: IHHMG

To setup an account with Office Ally please contact them directly at (866) 575-4120, or you can email them at Info@OfficeAlly.com

SECTION 18. PATIENT'S RIGHTS AND RESPONSIBILITIES

CALIFORNIA PATIENTS BILL OF RIGHTS (REGULATORY) Title 22, California Code of Regulations Section 72527

It is the Patient's Rights to:

1. Exercise these rights without regards to sex or cultural, economic, educational or religious background or the source of payment for the patient's care.

2. Considerate and respectful care.

3. Knowledge of the name of the physician who has primary responsibility for coordinating the patient's care and the professional relationships of other physicians who see the patient.

4. Receive information from the patient's physician about the patient, the course of treatment and the patient's prospects for recovery in terms that the patient can understand.

5. Receive as much information about any proposed treatment/procedure the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include the procedure/treatment, the significant medical risks involved, alternate course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.

6. Participate actively in decisions regarding the patient's medical care to the extent permitted by law; this includes the right to refuse treatment.

7. Full consideration of privacy concerning his/her medical program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

8. Confidential treatment of all communications and records pertaining to his/her care. Patient's written permission shall be obtained before medical records can be made available to anyone not directly concerned with his/her care.

9. Receive timely response to requests for services, including evaluations and referrals.

10. Leave the facility even against the advice of the patient's physician.

11. Continuity of care, advance notice of time and location of appointment and physician providing medical care.

12. Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment and the right to refuse to participate in such research projects.

13. Be informed by his/her physician or a delegate of his/her physician of his continuing health care requirements following the patient's discharge from the facility.

14. Examine and receive an explanation of the patient's bill regardless of source of payment.

15. Have all patients' rights apply to the person legally responsibility to make decisions regarding medical care.

16. Acquire information you desire about your Health Plan, including a clear explanation of benefits and services and how to receive them.

17. Obtain medically necessary health services, including preventive care.

18. Voice a complaint about a health plan or the care you receive through your plan's grievance and appeal procedures, and to receive a timely response to any complaints or inquiries regarding your benefits or care.

19. Discuss (and complete) an advance directive, living will or other health care directive with your health care provider.

20. Receive a second opinion when deemed necessary by the contracting medical group.

21. Receive emergency service when you, as a prudent layperson, believe that a life-threatening emergency occurred. Payment will not be withheld in such cases.

22. Receive urgently needed services when traveling outside of the service area.

23. Not be discouraged to enroll in, or be directed to enroll in, any particular Medicare Choice plans.

It is the Patient's Responsibility to:

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

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

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

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

Imperial Health Holdings Medical Group
Member Satisfaction Survey

1. How long did you wait to get an appointment

To see your primary care doctor □ within 1 wk □1-2 wks □ 3 weeks □4 or more wks

To see a Specialist □ within 1 wk □1-2 wks □ 3 weeks □4 or more wks

2. How long did you wait to see your physician once you have arrived at his/her office (past your appointment time?) □ 0-30 Min □ 30-60 min □ 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 IPA? □ 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 program (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 wk □ 1-2 wks □ 3 weeks □ 4 or more wks □ Not applicable

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

14. Did your provider explain to you about your rights and responsibilities as a member of AHC IPA? □ Yes □ No

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

16. Did your provider give you Cultural & Linguistic information/referral for your health concern? □ 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 Holdings Medial Group 600 South Lake Ave Suite 308 Pasadena, CA 91106

Imperial Health Holdings Medical Group
600 S Lake Ave, Suite 308
Pasadena, CA 91106

2017 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 Holdings Medical Group and **FAX** it back to **626-205-9537**. Thank you for your participation.

ADMINISTRATIVE SECTION

Provider Relations

1. I have been supplied with:

A Provider orientation YES ☐ NO ☐

Access to the Web Portal YES ☐ NO ☐

2. My Provider Relations Representative 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 IHHMG accepts electronic claims submission through Office Ally?

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 IHHMG are accurate

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

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

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Utilization Management

10. UM Representatives are helpful

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

11. Referrals are processed in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

12. Denial notifications consistently provided denial reasons

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Credentialing

13. The Credentialing process occurred in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

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

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

15. Credentialing Coordinator is courteous and knowledgeable

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Please provide additional comments or suggestions:

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

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

600 South Lake Ave Suite 308
Pasadena, CA 91106

Quick Reference Sheet

Main Number	(626) 838-5100
Main Fax	(626) 521-6028
Eligibility	(626) 838-5100 Option 2

Utilization Management	(626) 838-5100 Option 1
Utilization Management	Fax (626) 364-0329
After Hours Nurse Line	(626) 838-5100

Claims Department	(626) 838-5100 Option 3
Claims Forwarding Address	P.O. Box 60075 Pasadena, CA 91116
Claims Payer ID (Electronic Submission)	Office Ally: IHHMG

Contracting/Provider Services	(626) 838-5100 Option 4
Contracting/ Provider Service Fax	(626) 205-9536