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**Provider  
Reference  
Manual**

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## Introduction

Welcome to Independent Medical Systems, Ltd (IMS) a Texas Preferred Provider Organization (PPO) that includes one of the state's largest and fastest growing networks. IMS' network of healthcare providers includes more than 28,000 physicians, 5,000 ancillary providers, and 325 facilities. As one of the oldest state wide networks IMS has been operating since 1989 serving Insurers , Third Party Administrators (TPA), Self-Funded Employers and Union Trust Funds.

This manual is designed to aid in your orientation as a new IMS network provider. The following is a guide for office personnel to follow when your practice or facility treats IMS covered individuals. A covered individual is any person eligible to receive care, treatments and supplies for which payment is available pursuant to a contract offered by an IMS Payor.

At IMS we realize that the key to our success is our strong commitment to positive relationships with our network providers. To strengthen these relationships we provide you with a fast and friendly way to view the most up to date information on the Provider Section of our website at <http://www.imsppo.com>. You may also request a current copy of our most recent list of Payors by calling the IMS Provider Relations Department at 1-800-853-7003.

## IMS at a Glance

- IMS is a PPO network consisting of facilities, physicians and ancillary healthcare providers contracted to provide medical services.
- Pre-certification is typically not required for most in-office procedures. However, surgeries, non-emergency admissions, and high cost diagnostics generally do require pre-certification as described in the Medical Management Section on page 7.
- IMS network Payors offer benefits to covered individuals who seek medical care outside of the network (out-of-network benefits). However, there are strong financial incentives for covered individuals to see in-network providers.
- IMS assumes NO cost risk for treatment such as capitation, risk pools, etc. Payment is issued by the insurance company, self-funded employer or third party administrator.
- IMS credentials and re-credentials all network providers. IMS has established and updates from time to time its credentialing criteria for all categories of providers it accepts into its Network.
- IMS client contracts are with the claim payors. IMS is not an insurer, guarantor or payor of claims and is not liable for any payment of claims submitted by the provider to IMS or any IMS payor.

## Reimbursement and Billing

Covered individuals should be registered according to your normal patient registration process. Whenever possible - and dependent on your system's capability - the registering of patients should include the covered individual's administrator and Payor information, with the IMS information as secondary. Please remember, IMS is a network and never the Payor. This helps to apply payments more quickly and accurately. Additionally, having the covered individual's employer and administrator names will enable your IMS Provider Relations Representative to assist you more effectively with any problem resolution.

IMS Payors furnish covered individuals with a means of identifying themselves as covered under a contract. Methods of identification include, but are not limited to, identification cards; affixing the IMS logo to identification cards; or a telephone number to call for verification of the covered individual's eligibility. Always contact the IMS Payor to obtain eligibility and benefit information before rendering services. Please note that confirmation of eligibility does not guarantee payment. Benefit restrictions may apply. Be sure to notify covered individuals of restrictions identified when contacting the IMS Payor.

All plans have admission review requirements through their Medical Management programs. Non-emergency admissions must be pre-certified at least two (2) days prior to admission. Emergency, urgent, and maternity admissions must be certified no later than the next business day following admission. An emergency is defined as follows:

A sudden unexpected illness or injury which requires the immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the Member or represent a serious threat to the life or limb of a Member.

If you have any difficulty locating Medical Management phone numbers, please contact IMS' Customer Service Department, which should be able to provide you with the appropriate number. This information is listed either by administrator/insurer or by employer/union. The member group medical ID card is the best reference for this information. You should have this information available before calling Customer Service at 800-853-7003.

Compensation is determined by the terms of the network participation agreement between the provider and IMS. As a preferred provider, you agree to submit to the IMS Payor (whether primary or secondary) a timely, clean claim for services rendered to covered individuals. All claims should be submitted with your regular billing rates using industry standard coding guidelines. Claims must be submitted to the address found on the covered individual's ID Card using a current appropriate claim form. Please be sure to review the explanation of benefits (EOB) form sent to you by the IMS Payor to determine the amount billable to the covered individual. At the time of the visit, you may collect any co-payment or encounter fee specified in the covered individual's contract. Following the receipt of an EOB, you may bill for deductibles and co-insurance, if any, as specified in the covered individual's contract, and/or payment for non-covered care. Covered individuals can not be billed for the difference between your total billed charges and the IMS negotiated rate.

## Provider Appeal Process

If the provider receives a payment or denial of benefits that they disagree with, they should follow the normal channels to appeal the payment or denial. The first step would be to contact the Payor directly through their member service call center (telephone number would be displayed on the member's ID card). The provider should express the reason they feel the claim was not adjudicated properly and ask for a verbal response from the Payor. If the claim was partially or totally denied due to pre-certification reasons, the provider may need to also contact the Utilization Review Department/vendor directly.

This first level of appeal may satisfy the provider and end the appeals process for this claim. If the provider still feels that the payment or denial is unjustified, they should follow the second level appeals process and submit a written letter directly to the Payor's appeals/grievance department. They would need to state the specific facts they are disputing, and indicate that they have already filed a first level appeal. The provider should expect that a written appeal might take approximately thirty (30) days to receive a response. Depending on the circumstances of the claim the provider should allow the Payor adequate time to perform a full investigation of all the issues.

At any time during the appeals process, the provider may contact its Provider Relations Representative. If the provider is filing a second level appeal, copies should also be sent to IMS.

Certain appeal processes may vary from time to time due to the specific line of business and Payor to which they are appealing.

# Medical Management

## How Medical Management Is Performed In Each Group.

IMS' clients provide their own Medical Management programs. The program may be proprietary to the client or contracted to a vendor. Programs are not standardized, but the following represents the features that will be encompassed. IMS anticipates that its contracted providers will cooperate with our clients' Medical Management programs.

Certifying treatment with the Medical Management program does not guarantee payment for services rendered. Certifications are subject to retrospective review and approval and in cases where multiple procedures are performed, be sure to confirm benefit eligibility from the IMS Payor for each procedure.

## Typical Medical Management Programs

Medical Management will frequently include each of the following medical cost management programs:

- A nurse call center available during normal business hours.
- Inpatient review encompassing medical, surgical, psychiatric, substance abuse and rehabilitation care.
- Hospital pre-Admission review for non-emergencies.
- Post admission review for urgent and emergency admissions.
- Concurrent/continued stay review.
- Discharge planning, in cases where appropriate.
- Screening and referral to large case and disease management programs.
- Managed Second Surgical Opinion Program.
- Steerage to appropriate PPO and ancillary providers.

## Inpatient Admission Review

All inpatient admissions must be reviewed for medical necessity. Scheduled admissions should be reviewed at least seventy two (72) hours in advance of the admission. Urgent or emergency admissions must be reviewed the next business day following admission.

The admission review process should be initiated by the hospital or the physician. Many programs will, however, involve the covered individual regarding the options and alternatives available under the client's benefit plan. In many instances the review nurse will assign an initial expected length of stay, which will be determined from a clinical database.

A concurrent review process will be based on a schedule determined by the initial assigned length of stay, or the judgment of the nurse reviewer as to the appropriate follow-up intervals. Concurrent review will be conducted either with the hospital UR department, the floor nurse, or the attending physician. In all instances the nurse reviewer will need to determine the discharge day and its appropriateness.

The Concurrent Review process is initiated by the nurse reviewer. The covered individual may be too ill to be discharged and should not have the burden of notifying the nurse reviewer as well. The nurse reviewer also works with provider personnel to assist in assessing the covered individual's condition, especially in those cases that can change rapidly, such as a covered individual admitted for acute abdominal pain. Contact with the floor nurse can offer the most up-to-date information regarding the covered individual's condition without disrupting the physician. However, it should be noted, in the majority of cases the physician is the individual contacted in reference to the covered individual's condition.

Clinical Review Criteria is derived from one of the following sources:

### **Large Case and Disease Management**

Large Case and Disease Management encompass both catastrophic and chronic care management. Each requires a different approach, but the common thread is that each must have a case manager as the interventionist.

Large Case and Disease Management services are designed to maximize healthcare dollars by seeking the most cost and care effective environment and services for the covered individual. Programs will vary slightly by client. Case Managers seek to affect quality of life, quality of care, and cost of care. Care is coordinated across multiple providers, and special discharge arrangements may be made by the Case Manager. Most importantly, the covered individual and family are involved in the decision-making process from the onset, because covered individuals with chronic or catastrophic illnesses are not solely affected; the entire family is touched by these circumstances.

Covered individuals appropriate for case management are identified through the Pre-Admission Review process, Concurrent Review process, and Medical Information Helpline, as well as through claims processing or client notification, for those covered individuals who have either not come through the utilization review process and/or who have expensive, chronic outpatient care.

Ongoing monitoring is performed to ensure that quality and frequencies of services are appropriate. The ongoing review will also provide information in the event that revisions are required to the original recommendations regarding items such as level of care or frequency of care. Case management may be applied to any type of admission.

Case Managers are heavily involved from the date of authorization (this will come from IMS' client or the administrator of the covered individual's benefit plan), in the development of a treatment plan. They speak with the physician and work in a cooperative manner with both the physician and family members involved.

The Case Managers are both nurses and physician assistants who have expertise in a multitude of specialties; all have extensive clinical experience in their particular specialty. Case Managers are familiar with local resources and utilize specialist Case Managers, such as Certified Rehabilitation Nurses for spinal cord or head injury covered individuals and Neonatal Practitioners for premature babies. The covered individual and family are involved in the decision-making process from the onset, because covered individuals with chronic or catastrophic illnesses are not solely affected; the entire family is touched by these circumstances.

## Managed Second Surgical Opinion Program

Client medical plans will generally pay for a needed second surgical opinion. At any time, a covered individual may obtain a voluntary second surgical opinion, and a third surgical opinion in the case of a disagreement between the first and second opinion.

In most instances the medical plan will contain a program to encourage use of second surgical opinions. The majority of plans will have a managed second surgical opinion program, which means that the need for a second surgical opinion will be determined by the nurse reviewer at the time that the admission review is done. If the nurse reviewer determines that a second surgical opinion is needed, then the admission will not be certified until the opinion is obtained.

Some plans will have a published list of procedures for which it is necessary to obtain a second surgical opinion. The lists will vary from client to client, and it would not be possible for a provider to have all the lists. Information regarding the second opinion is provided at the time that the admission is certified. The covered individual must have presented evidence that a second surgical opinion has been obtained.

## Optional Outpatient Review Programs

Certain clients will elect to purchase outpatient review programs. Typically, these programs will review ambulatory surgery performed in the same-day surgery unit of the provider or in a free-standing surgi-center. In addition, most programs will review higher cost diagnostics procedures such as MRIs and CT Scans. Some clients will have a defined list of procedures to be reviewed, and others will review all outpatient procedures done by the provider. As with second surgical opinions, it will not be possible to provide a list of procedures for each client.

IMS' clients will expect notification at least 48 hours in advance of a planned admission. Notification within 24 hours or the next working day following an emergency admission is preferred. Pre-certification numbers are available on the covered individual's ID cards. For assistance in locating those numbers, please contact IMS' Customer Service at 800-853-7003

If the covered individual requires laboratory, radiology or home health care services, IMS has developed an extensive ancillary network consisting of laboratories, radiology service sites and home health care providers. Please be aware that some of our clients have specific rules regarding laboratory services and may only cover lab work performed by specific providers. This information is typically outlined on the covered individual's ID card. When these types of services are required, IMS requests that preferred providers refer covered individuals to an ancillary provider within the IMS PPO network. For assistance in finding other IMS PPO providers or assistance for referral purposes and or questions, contact the Provider Relations Department toll-free at 800-853-7003.

## Appeals Process for Care Management Decisions

The appeals process may vary by the Payor's Medical Management program and/ or as mandated by state or federal law. In the event you or a covered individual do not agree with a non-certification determination made under the Medical Management program, you or the covered individual have the right to appeal the determination in accordance with the IMS Payor's Medical Management program appeals process. To obtain details of the IMS Payor's Medical Management program appeals process, please contact the appropriate IMS Payor.

