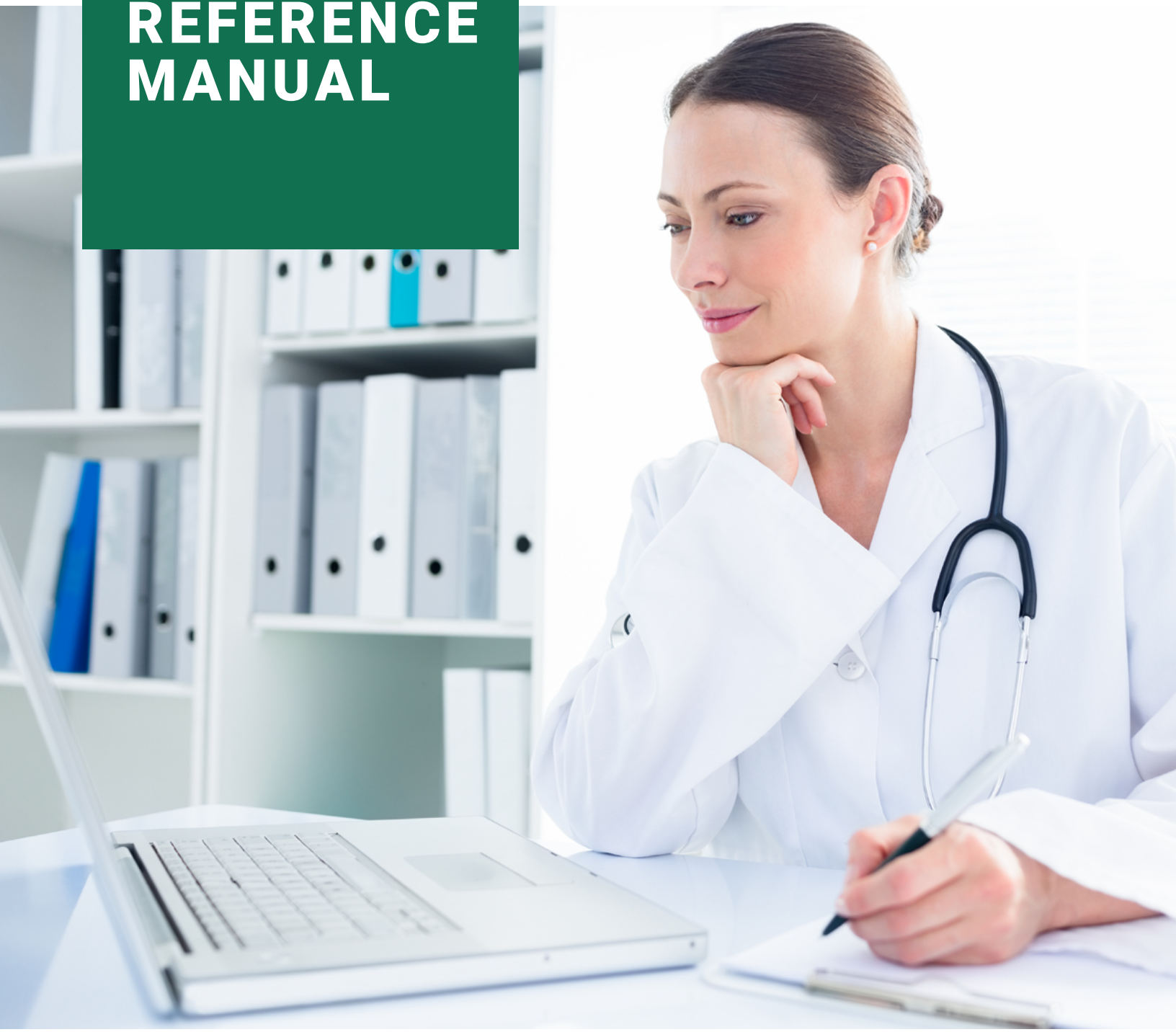
PROVIDER **REFERENCE MANUAL**



INDEPENDENT MEDICAL SYSTEMS

INTRODUCTION

Welcome to Independent Medical Systems, Ltd (IMS), a Texas Preferred Provider Organization (PPO) that offers one of the state's largest and fastest growing networks with more than 48,000 physicians, 7,500 ancillary providers and 335 acute care facilities.

Operating since 1989, IMS is one of the oldest statewide networks and serves insurers, third party administrators (TPA), self-funded employers and union trust funds.

This manual is designed to help you as a new IMS network provider and includes a guide for office personnel to follow when your practice or facility treats individuals covered by IMS. A covered individual is any person eligible to receive care, treatments and supplies that are paid pursuant to a contract offered by an IMS payer.

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 www.imsppo.com. You may also request a current copy of our most recent list of Payors by calling the IMS Network Development Department at 1-800-853-7003.

IMS AT A GLANCE

- IMS is a PPO network consisting of acute care facilities, physicians and ancillary healthcare providers contracted to provide medical services.
- 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 occasionally updates its credentialing criteria for all categories of providers it accepts into its network.
- IMS client contracts are with the claim payers. IMS is not an insurer, guarantor or payer of claims and is not liable for any payment of claims submitted by the provider to IMS or any IMS payer.

REIMBURSEMENT AND BILLING

COVERED INDIVIDUALS

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 payer information, with the IMS information as secondary.

Please remember that IMS is a network and never the payer. 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 payers provide covered individuals with a way to identify 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 payer to obtain eligibility and benefit information before rendering services.

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 payer.

PRE-CERTIFICATION

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."

MEDICAL MANAGEMENT NUMBERS

If you have any difficulty locating medical management phone numbers, please contact the IMS customer service department, which will provide you with the appropriate number. This information is listed either by the administrator/insurer or by the 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 1-800-853-7003.

COMPENSATION

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 payer (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 and appropriate claim form. Please be sure to review the explanation of benefits (EOB) form sent to you by the IMS payer 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 cannot be billed for the difference between your total billed charges and the IMS negotiated rate.

PROVIDER APPEAL PROCESS

If you receive a payment or denial of benefits that you disagree with, you must follow the below procedure to appeal the payment or denial.

The first step is to contact the payer directly through the member service call center. This phone number should be displayed on the member's ID card. Explain why you feel that the claim was not adjudicated properly and ask for a verbal response from the payer. If the claim was partially or totally denied due to pre-certification reasons, you may also need to contact the utilization review department or vendor directly.

This first level of appeal may satisfy you and end the appeals process for this claim. If you still feel that the payment or denial is unjustified, you should follow the second level of the appeals process and submit a written letter directly to the payer's appeals or grievance department. State the specific facts that you are disputing, and indicate that you have already filed a first level appeal.

You should expect a written appeal to take approximately thirty (30) days to receive a response. Depending on the circumstances of the claim, you should allow the payer adequate time to perform a full investigation of all the issues.

At any time during the appeals process, you may contact your IMS Provider Relations Representative. If you are filing a second level appeal, you must also send copies of the relevant documents to IMS.

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

QUESTIONS?

To speak to an IMS Provider Relations Representative, call 1-800-853-7003 from Monday through Friday between 8 a.m. to 5 p.m. Central Standard Time.

www.imsppo.com