Paramount Healthcare

UTILIZATION MANAGEMENT
DECISION TIMEFRAMES

Medicare			
Type of Service	**Decision Standard**	**Approval Notification (telephonic/electronic/written) Provider (P) & Member (M)*** **	**Denial Notification (telephonic written/electronic) Provider (P) & Member (M)**
Precertification Non-Urgent	14 calendar days from date of receipt	14 calendar days from date of receipt Telephonic M Electronic/written P & M	14 calendar days from date of receipt Telephonic M Electronic/written P & M (within 3 days of verbal)
Precertification Urgent	Within 72 hours, (3) calendar days, of receipt of the request	Within 72 hours, (3) calendar days, of receipt of the request Telephonic M Electronic/written P & M	Within 72 hours, (3) calendar days, of receipt of the request P & M Successful telephonic member notification allows additional 3 days for written notification.
Concurrent	Within 72 hours, (3) calendar days, of receipt of the request	Within 72 hours, (3) calendar days, of receipt of the request P & M	Within 72 hours, (3) calendar days, of receipt of the request P & M
Concurrent Urgent	Within 72 hours, (3) calendar days, of receipt of the request	Within 72 hours, (3) calendar days, of receipt of the request P & M	Within 72 hours, (3) calendar days, of receipt of the request P & M Successful telephonic member notification allows additional 3 days for written notification.
Retrospective	Within thirty (30) calendar days of receipt of the request.	Within thirty (30) calendar days of receipt of the request. P & M	Within thirty (30) calendar days of receipt of the request. P & M (if member has financial liability)
Medication in provider setting (part B medication)*	Within 72 hours, (3) calendar days, of receipt of the request	Within 72 hours, (3) calendar days, of receipt of the request P & M	Within 72 hours, (3) calendar days, of receipt of the request P & M
Urgent-Medication in provider setting (part B medication)*	Within 24 hours, (1) calendar day, of initial request	Within 24 hours, (1) calendar day, of initial request P & M	Within 24 hours, (1) calendar day, of initial request P & M

Paramount Commercial			
OHIO HMO/HIX, PPO, CDHP			
Type of Service	**Decision Standard**	**Approval Notification (telephonic/electronic/written) Provider (P) & Member (M)** NCQA	**Denial Notification (telephonic/ written/electronic) Provider (P) & Member (M)**
Precertification Non-Urgent	With 15 calendar days of the receipt of the request **after obtaining all necessary information	Electronic/written (P&**M**) within 15 calendar days of the request.	Electronic/written (P&M) within 15 calendar days of the request
Precertification Urgent	Within (72 hours of receipt of the request **after obtaining all necessary information	Electronic/written (P&**M**) within 72 hours of the request.	**Phone:** if verbal notification is completed; 3 additional calendar days to provide written or electronic notification Electronic/written (P&M) within 72 hours of the request
Concurrent * ORC 3923.041 (B)(4)(a)	Within 10 calendar days of receipt of the request **after obtaining all necessary information	Within 10 calendar days of the receipt of the request	Within 10 calendar days of the receipt of the request
Concurrent Urgent	Within (72 hours of receipt of the request **after obtaining all necessary information	Electronic/written (P&M) within 72 hours of the request.	Phone: if verbal notification is completed; 3 additional calendar days to provide written or electronic notification Electronic/written (P&M) within 72 hours of the request
*Any non-urgent request to extend a course of treatment previously approved by Paramount, may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim. If requests are not made **at least 24 hours prior to the expiration of the prescribed period of time** or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than seventy-two (72) hours after receipt.			
Retrospective	Within thirty (30) calendar days of receipt of the request. **after obtaining all necessary information	Within thirty (30) calendar days of receipt of the request. (P&M)	**Electronic/written (P&M)** Within 30 calendar days of request
In the event that a claim is submitted for a service for which prior authorization was required but not obtained, Paramount will permit a retrospective review of such a claim if the service in question meets all of the following: • The service is directly related to another service for which prior approval has already been obtained and that has already been performed. • The new service was not known to be needed at the time the original prior authorized service was performed. • The need for the new service was revealed at the time the original authorized service was performed.			

If the claim meets all three of these conditions, Paramount will review the claim for coverage and medical necessity once the written request and all necessary information are received.			
Provider Portal Submission Senate Bill 129			
Precertification of Non-Urgent care	Within ten (10) calendar days of receipt of request	Within ten (10) calendar days of receipt of request (P&M)	Within ten (10) calendar days of receipt of request (P&M)
Precertification of Urgent care	Within 48 hours, two (2) calendar days, of receipt of the request	Within 48 hours, two (2) calendar days, of receipt of the request (P&M)	Within 48 hours, two (2) calendar days, of receipt of the request (P&M)
If the Prior Authorization electronic request is incomplete, Paramount will indicate the specific additional information that is required to process the request within 24 hours of receipt of the request. The health care provider must provide a receipt to Paramount acknowledging the request.			

Pararamount Commercial/HIX			
Michigan HMO PPO. CDHP Large and small group			
Type of Service	**Decision Standard**	**Approval Notification (telephonic/electronic/written) Provider (P) & Member (M)**	**Denial Notification (telephonic/ written/electronic) Provider (P) & Member (M)**
Precertification Non-Urgent	Within (15) calendar days of receipt of request	Within (15) calendar days of receipt of request	**Electronic/written** (P & M) within 15 calendar days of the request
Precertification Urgent	Within 72 hours, (3) calendar days of receipt of the request	Electronic/written (P&M) within 72 hours of the request	**Phone**: If verbal notification is completed; 3 additional calendar days to provide written or electronic notification; **Electronic/written (P&M)** within 72 hours of the request
Concurrent	Within 10 calendar days of receipt of request	Within (10) calendar days of receipt of the request	**Electronic/Written (P&M)** within 10 calendar days of receipt of the request
Concurrent Urgent	Within 72 hours, (3) calendar days of receipt of the request	Electronic/written (P&M) within 72 hours of the request	**Phone**: If verbal notification is completed; 3 additional calendar days to provide written or electronic notification; **Electronic/written (P&M)** within 72 hours of the request
Retrospective	Within thirty (30) calendar days of receipt of the request.	Within thirty (30) calendar days of receipt of the request. (provider only)	Within thirty (30) calendar days of receipt of the request. Member only receives this notification if financially liable. (i.e., OOP)

Revised 1/2025
Timeframe excerpts taken from UM Procedures E7b-d