PARAMOUNT
PO Box 928 | Toledo, OH 43697-0928

Paramount Provider Manual

PARAMOUNT

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Dear Paramount Provider:

Thank you for being a valued Paramount partner. Please know, we are always looking for ways to make your job easier. The purpose of this manual is to serve as your guide to navigating Paramount policies, programs, processes, procedures, and member benefits for each of our plans.

At Paramount, high-quality, responsive, and simplified insurance is what drives us. The health and satisfaction of our members is our top priority. We consistently work to create innovative insurance products that meet the demands of our members throughout their lives.

Remember, you can access the MyParamount online portal or call our provider inquiry team at 888-891-2564 for claim and prior authorization statuses, member benefits and eligibility.

Our provider relations team is on hand if you have additional questions. Please call 800-891-2542.
In addition, stay informed on Paramount's latest provider news by visiting ParamountHealthcare.com/providers/tools-and-resources/provider-and- network-news.

We look forward to our continued partnership and to meeting our shared goal of reaching optimal outcomes for patient members.

Thank you,

Lori A. Johnston

Lori A. Johnston, President, Paramount Health Care

Section 1: Provider Resources

Paramount Digital Tools

Our goal is to ensure that you, our providers, always have convenient access to the information you need from Paramount.

Paramounthealthcare.com

Paramount designed the Provider website to make navigation easy and useful for our providers. There, you'll find essential information on our departments and information to assist providers when working with Paramount. Go to Paramounthealthcare.com select For Providers and choose content from drop down menu.

Some content accessed from the provider home page menu include:

- Claims and Authorizations
- Outpatient Prior Authorizations
    - Medical Drug Prior Authorizations
    - Electronic Claims Submissions
    - Utilization Management
- Condition Management
- Medical Policies Overview
    - Medical Policy Library
- Reimbursement Policies
- Prescription Drug Program Overview
    - Specialty Drug Program
    - Preferred and Preventative Drugs
    - Drug and Specialty Drug Prior Authorization
- Additional Tools and Resources
    - This section provides commonly used documents, forms, and frequently asked questions.
- CultureVision® - Services Provided in a Culturally Competent Manner

  Paramount contracted providers must deliver covered services to all covered persons in a culturally competent manner, including those covered persons with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. Paramount now offers CultureVision® as a resource to support cultural competency. Additional resources and training courses for providing culturally competent care can be accessed online at Paramounthealthcare.com.
- Quality improvement initiatives.
- Special program information.
- Utilization management practices.

Provider Newsletter

Published twice a year as a service for our provider and office manager community, the Paramount Network News is mailed to offices and posted on our website at https://www.paramounthealthcare.com/providers/tools-and-resources.

Each issue includes valuable information for Paramount providers, such as:

- Care management referral instructions.
- Claims management and clinical document suggestions.
- Clinical practice guidelines.
- Health care access and availability standards expectations.
- Formulary and prescribing criteria.
- Medical Advisory Council decisions.
- Member rights and responsibilities.
- Program evaluations and survey results.
- Quality improvement initiatives.
- Special program information.
- Utilization management practices.

Provider Notices

Paramount sends monthly email and fax communications to its network regarding policy changes, new program requirements, and important announcements to keep you informed. The provider notice updates will also be housed on our medical policy overview page, located on our website.

To guarantee timely delivery, please ensure that we have your most recent email address on file. If we do not have your email address or you would like to change it, please complete, and submit our Provider Information Change Form.

Paramount Provider Directory

Providers can review and confirm their network participation status by using our Find a Provider search tool. A search can be done by Provider or Group name, viewing a list of local providers by zip code.
You can also narrow the search down by specialty, product line, and provider ID.

- Go to MyParamount.org.
- Select Find a Provider.

It is vital that members receive accurate and current information related to provider availability. Providers must notify Paramount of any demographic changes. All requests must be received 30 days prior to change or update. Any request received within less than 30 days' notice will be assigned a future effective date. Contractual agreements may supersede effective date requests.

Types of demographic changes/updates can include, but are not limited to:

- Accepting new patients.
- Address-Additions/Closings of location.
- Email Address.
- Name Changes.
- Hours of Operation.
- Phone/Fax Numbers.
- Termination.

To request participation for a new provider to join an existing group, providers must first begin the application process. Go to Join our Network.

In addition, providers are encouraged to submit a provider roster to Credentialing for streamlined processing of provider data additions, changes, and terminations using our standard Microsoft Excel document. The document is located under Tools and Resources.

You will be fully credentialed upon applying to the Paramount Network. Paramount recredentials practitioners on a three-year cycle, by specialty. This will happen automatically, and Paramount credentialing staff will reach out to your office if information is required. Please make sure to keep your CAQH application current.

Paramount recognizes the below noted specialties as Primary Care Providers (PCPS).

- Family Medicine.
- Internal Medicine.
- Pediatrics.
- Adolescent Medicine.
- Geriatric Medicine.
- Certified Nurse Practitioner.
- Physician Assistant.

Provider Inquiry And Provider Relations Departments

If you cannot find the information you need on MyParamount or our Paramount website, please con- tact Paramount's provider inquiry team at 888-891-2564. Staff is available to assist you Monday – Friday, 8:30 AM. – 5 PM.

For more complex issues, please work with your provider relations representative. You can reach our provider relations team at 800-891-2542 or Provider.Relations.Paramount@Medmutual.com.

MyParamount: Online Portal

The MyParamount Portal is your central resource for claims, prior authorizations, and member coverage details. The online portal is password protected and HIPAA compliant. It allows you to:

- Find participating providers from our provider directory.
- Send and receive messages to/from our provider inquiry team through the message center.
- Submit and view claims information, such as diagnosis and procedure codes, and payment status.
- Submit and view prior authorizations.
- View and download EOPs (explanations of payment).
- View member eligibility and benefits information, including their health insurance carrier, policy number, and effective dates of coverage.
- View deductible and out of pocket accumulators.
- View panels of members assigned to primary care providers.

To register for an account, please take the following steps:

- Visit myparamount.org.
- Choose "Provider Registration" in the top right corner.
- Review and accept the Terms of Use Agreement, which states that our portal is in accordance with HIPAA privacy regulations and Paramount policies. Then, click "Next."
- Enter your tax ID, your 5-digit Paramount provider ID or NPI number, and a recent claim number (for access to claims information). Then, click "Next."
- Complete the registration instructions, and then click "Submit."
- Once you have completed these steps, you will receive an email with a link to finish your registration.

Note: We recommend designating an administrator from your practice. The administrator can assign access levels to other members of the practice, designate user roles, and add or remove additional users.

Important Contact Information

Below is a complete list of Paramount departments and contact information for each.

Department	Assistance Available	Contact
Credentialing Monday – Friday 8:30 a.m. – 5 p.m.	• New provider applications • Re-credentialing questions	Email: PHCCredentialing@MedMutual.com
Member Services Commercial, Marketplace Exchange, OBA Monday - Friday 8 a.m. – 5 p.m. Medicare April – September Monday – Friday 8 a.m. – 8 p.m. October – March Sunday – Saturday 8 a.m. – 8 p.m.	• Member questions and complaints • Primary care provider update requests • Interpreter services • Special Needs documentation	Phone: 800-462-3589 Phone (TTY): 888-740-5670 Fax: 419-887-2047 Email: Paramount.MemberServices@MedMutual.com Medicare dedicated phone: 833-554-2335 Phone (TTY): 888-740-5670
Pharmacy Monday – Friday 8 a.m. – 5 p.m.	• Obtaining drug prior authorizations	CVS Caremark Phone: 1-855-749-0851 (TTY 711) Fax: 1-855-633-7673
Provider Inquiry Monday – Friday 8:30 a.m. – 5 p.m.	• Member benefits and eligibility • Claim status inquiries. • Claim processing issues. • Referral/authorization verification	Phone: 888-891-2564 Fax: 419-887-2014 Email: Paramount.ProviderInquiry@MedMutual.com
Provider Relations Monday – Friday 8:30 a.m. – 5 p.m.	• Provider and office staff education • Contract issues • Orientations/webinars • New product participation requests • Representative office visit requests	Phone: 800-891-2542 Fax: 567-585-9403 Email: ProviderRelations.Paramount@MedMutual.com
Quality Improvement Monday – Friday 8:30 a.m. – 5 p.m.	• Information/questions	Email: PHCQuality@medmutual.com
Utilization/Case Management Monday – Friday 8 a.m. – 5 p.m.	• Obtaining in-plan and out-of-plan prior authorizations • Case/care management • BH out-of-plan requests • General clinical inquiries	Phone: 800-891-2520 Fax: 567-661-0847 567-661-0841 Mental health, chemical dependency 567-661-0842 General inquiries 567-661-0843 Home health care 567-661-0844 Imaging 567-661-0845 Inpatient, acute care 567-661-0846 Med., surg., DME, genetics, pre-D 567-661-0847 Out-of-plan 567-661-0848 SNF, rehabilitation, LTAC 567-585-9500 Provider Appeals

Section 2: Claims

Electronic Claims

Paramount strongly recommends Electronic Claims Submission, through the provider's preferred clearinghouse or through MyParamount portal, TransShuttle. Paramount will be moving to requiring electronic claims by 2025. Please contact an electronic claim submission coordinator to help you with this process.
Paramount currently accepts electronic claims submissions from a variety of clearinghouses. To submit claims using a clearinghouse vendor, you will need to sign our Trading Partner Agreement. list of clearinghouses, along with our Trading Partner Agreement form, which is available on our website.

If you would like to learn more about our electronic claim's submission process, please visit our website or contact PHCECShelpdesk@medmutual.com

Additionally, MyParamount portal, TransShuttle, offers the following benefits to claims processing:

- Convenient access: Available 24/7 at no additional cost.
- Enhanced capabilities: submit corrected claims, and void claims.
- Timely statuses: Check claims statuses and receive timely notification of changes in status.

If you need access to TransShuttle, please email ProviderRelations.Paramount@MedMutual.com

Paper Claims

Paper claims need to comply with the same standards as those for electronic submissions, set forth by the American National Standards Institute (ANSI).
Please review and adhere to the following requirements:

- Paramount will only accept the most current version of the industry standard CMS-1500 (02-12) and UB-04 forms printed in red drop-out ink.
- Printed information should go on the reverse side of the form. All mandatory fields on paper claim forms must be completed.
- Black and white versions of claim forms, including photocopied or faxed versions, and resized forms that do not replicate the scale and color of the standard claim form will not be accepted.
- The size of the form should be 8 ½ X 11 with the printer pin-feed edges removed along the perforations.
- Forms should be free from excessive creases or tears. Do not fold or staple forms.
- Forms should be clean and free from stains, notations, strike outs, crossed out or highlighted information, liquid correction tape, glue, and tape.
- Please use industry-standard procedure codes, diagnosis codes, location codes and modifiers.
- Paper claims should be mailed to: Paramount, P.O. Box 497, Toledo, OH 43697-0497.

Nonstandard forms will be returned to the address identified in Box 33 of the CMS-1500 form or Box 1 of the UB-04 form with instructions to resubmit the claim using the appropriate claim form. A new claim with the correct information must be submitted for the claim to be processed.

HIPAA 5010 Transactions

In 2009, the United States Department of Health and Human Services released a final rule to update standards for electronic health care and pharmacy transactions. This was in preparation for implementing ICD-10 CM (Case Management) codes on October 1, 2015.

Claim Requirements

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claim's submissions. Claims submitted without these numbers will be rejected. Please contact your Electronic Data Interchange (EDI) vendor if you have questions regarding where these identifying numbers should be placed on your forms.

Please note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering Provider's NPI and, if applicable, Box 33A for the group NPI.
- UB04: Box 56.
- ADA: Box 54 for the treating Provider's NPI and, if applicable, Box 49 for the group NPI.

Payment Processing Guidelines

Providers are responsible for the accuracy of claim submissions. Please adhere to the following coding requirements:

- For Diagnoses: International Classification of Diseases, 10th Revision, Clinical Modification ICD- 10-CM.
- For Professional And Outpatient Procedures: The Health care Common Procedure Coding System Level 1 (CPT (Current Procedural Terminology) codes), Level 2 and 3 (HCPCS codes).
- For Inpatient Hospital Claims: ICD-10-PCS (International BD Classification of Diseases, 10th Revision, Procedure Coding System).
- Claims must be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Submission Timely Filing

Time Limit for Submitting Claims

All claims, unless otherwise noted in the contract, must be filed within 12 months of the date of service. This policy is consistent with your Provider Agreement, Industry Standards, and the Company's ongoing efforts to better manage healthcare costs. Healthcare providers who contract with the Company may not hold Covered Persons responsible for claims submitted past the filing limit. Covered Persons who receive healthcare services from non-contracting providers also are required to submit claims within the 12-month period.

Procedure/Diagnosis Codes

Providers must bill for services using the most current CMS-approved diagnostic and procedural coding available for the date the service or for the date of discharge if the claim is an inpatient facility claim.

Code Editing Software

Paramount utilizes comprehensive bundling logic software, which is fully automated to audit and verify the clinical accuracy of claims prior to payment. Our claims editing software application contains a set of rules to address coding inaccuracies such as unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to an accepted coding principle. Guidance surrounding the most likely clinical scenario is applied.

Editing Software is sophisticated and has clinical logic based on clinical practice and reimbursement standards, and input from medical experts. The software applies edits that are based on the following sources:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. NCCI status code indicator to determine packaging or discounting, including medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual.
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals).
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule.
- Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals.
- AMA resources.
- CPT manual.
- AMA website.
- Principles of CPT Coding.
- Coding with Modifiers.
- CPT Assistant.
- CPT Insider's View.
- CPT Assistant Archives.
- CPT Procedural Code Definitions.
- HCPCS Procedural Code Definitions.
- OPTUM CES.
- Billing Guidelines Published by Specialty Provider Associations.
- Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG).
- Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS).
- State-specific policies and procedures for billing professional and facility claims.
- Health Plan policies and provider contract considerations.

Claim Inquiry/Adjustment Filing Tips

The diverse types of claim inquiries should be handled in separate ways depending on what is being requested for review. Here are some examples:

- **Claim Inquiry:** These do not result in changes to claim payments, but the outcome may result in the initiation of an adjustment dispute. Once the provider receives an answer to the claim inquiry, they may begin the claim payment appeal process or dispute.
- **Claim Correspondence:** Paramount, at times, may require additional information to finalize a claim. Typically, these are noted on the Explanation of Payment (EOP). The claim, or part of the claim, may be denied as Paramount will request more information needed to process. Once the information is received, Paramount will use it to finalize the claim.
- **Corrected Claims:** Submit corrected claims only when updating information on the original claim. These require the original claim number, as submitting a new claim, to correct a claim, will result in a duplicate system denial. Submit the entire claim as a replacement with any additional information to correct. To correct a claim submitted to Paramount in error, submit the entire claim as a void/cancel of prior claim.
- **Claim Appeals:** Must be submitted with our Claim Adjustment/Coding Review Request form, located at Paramounthealthcare.com under Provider Resources > Documents and Forms. Please complete and return the form along with required attachments to:

  Mail: Paramount
  P.O. Box 497
  Toledo, Ohio 43697-0497
  Fax: 405-254-2124
  Email: Paramount.Docflow@medmutual.com

Claims and appeals must be submitted within the timely filing timeframe specified in the provider agreement.

Claims Payment Inquiries

In the Non-clinical Claim Payment Inquiries section, Paramount currently states that “All requests for adjustments must be received at the Company within 12 months from the original notice of denial. The Company will respond to your request within 30 days.”

We have updated that language, and the new language is as follows. “All requests for adjustments must be received at the Company within the claims timely filing period. The Company will make good faith efforts to respond to your request within 30 days.”

Section 3: Utilization Management

Overview

Utilization management (UM) ensures effective and efficient medical care, including behavioral health care. Paramount's UM Department performs internal reviews of medical policies and medical criteria through a Medical Policy Steering Committee to ensure Paramount is utilizing the most current clinically indicated criteria to perform medical necessity reviews. We evaluate the cost and quality of medical services provided by participating physicians, hospitals, and other ancillary providers. To ensure appropriate utilization, we evaluate both potential overutilization and underutilization.

Paramount's UM department maintains the quality, efficiency and appropriateness of health care services provided to Paramount members. We manage all UM activities, including prior authorization processing, concurrent review, discharge planning, transition of care coordination, and more. Our goal is to ensure Paramount members receive the proper level of care in the most appropriate setting, and that the resources utilized align with their insurance plan benefits.

Paramount adheres to nationally recognized criteria, medical policies, and state and federal guidelines to determine medical necessity and appropriateness of services. In addition, internal criteria standards are in place for appropriateness of care and the existence of coverage where other sources of standard are not defined.

Our program focuses on the following objectives:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. Our program is designed to identify patterns of utilization, such as overutilization, underutilization, and inefficient scheduling of resources.
- To ensure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally achievable quality of care.
- To educate medical providers and other health care professionals on appropriate and cost- effective use of health care resources.
- To ensure continuity in the transition of care process by fostering close collaboration with our case management team

For More Information

If you have questions regarding our UM program, decisions, or authorization of care, please visit our webpage or call us. The UM team is available at 800-891-2520, Monday – Friday, 8 AM – 5:00 PM. If you need to leave a voicemail after hours, we will return your call in one business day. You can also visit paramounthealthcare.com/providers to find information and documentation related to:

- Medical policies
- Prior authorization criteria, decision timeframes, and complete list
- Population health/condition management services
- Documents and Forms

Utilization Care Management Process

Paramount's UM departmental operations policies and procedures are reviewed annually. These policies and procedures serve as a framework of authority for our operational teams.

Our UM nurse reviewers are authorized to approve prior authorization requests when medical necessity criteria are met based upon medical policies, InterQual criteria, clinical criteria software, and/or appropriateness of care and services for covered services. Prior authorization requests which fail to meet medical policy and clinical criteria will be escalated to a medical director for final review and determination of medical necessity.

Paramount's medical directors, associate medical directors, clinical directors, and pharmacists are the only plan representatives who can deny a prior authorization request for a service based on medical necessity/ appropriateness. Paramount offers a direct conversation with a medical director if requested.

Neither providers nor internal Paramount staff are financially or otherwise compensated to encourage underutilization and/or denials.

Paramount works cooperatively with its participating providers to assure appropriate management of all aspects of the members' health care.

The primary care provider (PCP) is responsible for coordinating all aspects of the member's health care. Conversely, the member is responsible for coordinating his/her medical and behavioral health care through their PCP. Although in-network specialist referrals are not required by Paramount for claim payment, members are encouraged to seek their PCP's advice before seeking specialist consultation and treatment.

Inpatient / Acute Care

Post-Stabilization Care Services: These are services related to an emergency condition that a treating physician views as medically necessary after an emergency condition has been stabilized. Prior authorization is not required by Paramount for coverage of post-stabilization services when these services are provided in the emergency department.

Observation Stays: Paramount does not need to be notified of an in-plan observation stay if the stay is less than 48 hours (about 2 days). Non-participating providers need to submit clinical information for review, as authorization will be needed for billing. An observation longer than 48 hours (about 2 days) should be converted to inpatient and must meet admission criteria for payment. Paramount must be notified when observation stays are longer than 48 hours (about 2 days) or when they are converted to an inpatient status. Fax is the preferred method of communication (567-661-0845). Paramount's Provider Portal is also available for submission of the initial request.

Inpatient Admissions: Paramount requires notification of an inpatient stay by the end of the next business day following the admission Monday-Thursday; and by end of business day Tuesday for a Friday-Sunday admission. This includes elective admissions. The admitting face sheet with the patient's demographic information along with a clinical review should be submitted. The UM team will review and respond with an anticipated length of stay and request for the next review day considering the initial documentation meets inpatient criteria. Concurrent review clinical information should be faxed or called promptly by the Paramount assigned next review date. Please include contact information on the fax (name of facility, UM reviewer, fax, and telephone number). Fax is the preferred method of communication (567-661-0845). Paramount's provider portal is also available for submission of the initial request.

Transplant Services: require an authorization for inpatient admission.

Skilled Nursing Facility: Skilled Nursing Facility services require pre-certification, submitted by the facility to determine medical necessity and appropriate level of care. Forms for pre-certification of skilled nursing facility admissions and concurrent review are available on the Paramount website.

Elective Admissions: Bariatric surgery, reduction mammoplasty, orthognathic/maxillofacial surgery and potentially cosmetic surgery require prior authorization/approval of the procedure before admission.

Prior Authorizations

Some procedures, diagnostic services and drugs require prior authorization. Prior authorization is obtained by contacting us at 800-891-2520, fax: 567-661-0842.

Current prior authorization requirements may be found on our website. Click here.

Additional information on the services and requirements covered may be obtained from provider inquiry by calling 888-891-2564.

Clinical Provider Appeals

Paramount investigates the substance of all requests for appeals from Paramount contracted and non- contracted providers. We document any actions taken in a prompt manner and treat all cases equitably.

Contracted Clinical Provider Appeals must be submitted to Paramount utilizing the designated Clinical Provider Appeals Form with all required information completed to be considered for review. Non- contracted providers may submit all required information in writing without the designated form, but it is recommended to ensure proper routing and timely resolution. Note: Any forms printed from links in this manual are current as of the print date.

Providers must have the member's written consent to file pre-service appeals.

Required Documentation

- The covered person's name and identification number as shown on their ID card.
- The provider's name.
- The date of the service.
- The reason the provider disagrees with the denial.
- Any documentation or other written information to support the request.
- Non-contracted providers must submit a member signed Waiver of Liability (WOL) form.

Paramount will provide notification to the provider indicating the decision and the decision date.

Levels Of Appeal

Paramount will allow up to two levels of appeal.

- The initial, first level, appeal will be reviewed by an associate medical/clinical director.
- A second level appeal, if requested, will be reviewed by the senior medical director and/or Chief Medical Officer.
- Neither level of appeal will include practitioners involved in any previous decision.
- If the second level appeal denial is upheld, Paramount's decision is final and will not be reviewed for additional consideration.

If the first level appeal is not received within the indicated filing timeframes, the appeal will be dismissed administratively, and a second level appeal will not be considered for review.

Medicare non-contracted provider first level appeals with a fully or partially upheld denial determination are automatically forwarded to an Independent Review Entity (IRE) under current CMS guidelines.

Appeal Filing Timeframe

Appeal Filing Timeframe Periods are dictated by contractual language for contracted providers. Denial dates are determined by the date of provider notification of the denial for the Paramount Elite Medicare and Commercial product lines.

If no authorization was requested and a claims denial is issued, Paramount will utilize the Red Card date as the date the appeal timely filing begins.

For non-participating providers, an appeal must be filed within 65 days from the date the denial was issued. Paramount will respond to all non-participating provider appeals within 60 days.

Retrospective Reviews

Contracted providers have contractual language related to the availability and timeliness of retrospective reviews.

Non-contracted providers may secure a retrospective review by submitting information based on the date of service within guidelines of Paramount's reimbursement policy related to deadlines for claim submissions.

Paramount shall permit retrospective review where a prior authorization was required but not obtained (retro authorization). To qualify, the service must meet all the following:

- The service is directly related to another service for which prior approval has already been obtained and has already been performed.
- The new service was not known to be needed when the original PA service was performed.
- The need for the new service was revealed when the original authorized service was performed.

In addition, retrospective review may be conducted in the following situations:

- Due to a technical error on the Paramount side, a request was not received, and the provider can submit a fax confirmation of said transaction.
- A member is "retro" enrolled on to a Paramount plan and this information was not available to the provider when the service(s) were rendered.
- A member presents as self-pay and Paramount coverage is later determined.

Peer-To-Peer Reviews

Paramount provides a peer-to-peer review process for services which have been denied. A peer-to-peer request can be initiated up until the date of discharge for inpatient admissions and readmissions or as part of the provider appeal process.

Peer-To-Peer Review Requests: Must be requested and completed prior to the date of discharge. Please provide the name and direct telephone number of the treating provider along with two dates and times of their availability.

Commercial: The facility can submit a verbal or written request for a peer-to-peer review, which will then need to be completed prior to the date of discharge.

Medicare Advantage: Medicare peer-to-peer discussions do not follow the timelines noted above. Prior to issuing a denial, the provider will be offered the opportunity to schedule a peer-to-peer discussion within a timeframe that ensures the member/provider notification timelines are maintained.

Provider Appeals: When a peer-to-peer request is submitted post denial, the new peer-to-peer determination will be the date on which appeal timely filing begins. If no peer-to-peer was requested during the admission, the date of appeal timely filing will remain on the initial determination date.

Inpatient Authorizations: The requesting provider can submit a verbal or written request for a peer- to-peer discussion to be submitted and completed up until the date of discharge. For a weekend discharge, the request for the peer-to-peer may be requested and completed no later than the following Tuesday.

Outpatient Prior Authorizations: The requesting provider can submit a verbal or written request for a peer-to-peer discussion to be submitted and completed within seven (7) calendar days from the determination date.

Section 4: Care Management Program

Overview

Our care management program identifies and manages members who are at high risk for complex, costly, or long-term health care needs. Our care managers are registered nurses (RNs) or social worker:

- Coordinate care for members who have both behavioral health and medical conditions, often working together to enhance the member's outcome.
- Work 1:1 with members and their PCP to ensure that medically appropriate services are provided in a supportive cost-effective environment.
- Follow members through the continuum of care from home to office, home health care, in-patient hospitalizations, rehabilitation, skilled nursing facility, and help them transition home again.
- Assist with utilization of participating providers.

Care Management Goals

- Treat members in the least restrictive and most cost-effective setting and manner.
- Empower members to acquire knowledge, decision-making ability, and alteration in lifestyle to promote positive health outcomes.
- Support the PCP/specialist by reinforcing the treatment plan.
- Avoid complications and multiple admissions by early identification of problems and development of goals.
- Identify members who are inappropriately over utilizing the emergency room and educate them to utilize PCPs for care whenever possible.
- Foster communication between the PCP, specialists, and ancillary providers.
- Decrease premature deliveries by promoting prenatal care.
- Reduce the cost of care.
- Coordinate the services of social and public health agencies when applicable.

Role Of The Physician

As the primary care provider (PCP), you are responsible for coordinating all aspects of members' health care needs. Our care managers will assist you with the process. Please help us identify members who:

- Are experiencing a complicated pregnancy.
- Are at high risk for frequent hospitalizations.
- Are at high risk for complicated pregnancies.
- Are potential transplant cases.
- Are oncology patients with complications.
- Are medically unstable or complex.
- Do not adhere to their treatment plan, are non-compliant with medication management, and/or miss appointments.
- Have special health care needs.
- Have drug-seeking behavior.
- Have behavioral health needs.
- Inappropriately utilize the ER.
- Need specialized care.

Center of Medicare & Medicaid Services (CMS), and National Committee for Quality Assurance (NCQA) expects the evidence-based collaborative efforts between case management and the primary care physician to influence positively the health and well-being of our members.

Referrals

How To Make A Referral To Care Management

For Care Management, please send information to:

Commercial/Marketplace Case Management ParamountCommercialCaseManagement@medmutual.com
Medicare Case Management ParamountEliteCaseManagement@medmutual.com

Outpatient

Specialist Referrals: The primary care provider (PCP) may request a consultation from a participating specialist at any time. A referral is not required from Paramount prior to consultation with any participating specialist.

Emergency Room Services: Referrals are not required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Emergency Room services are covered if referred by an authorized plan representative, PCP, or plan specialist. A referral is not required for payment of Emergency Room services for an emergency medical condition; the plan may do retrospective claim review to ensure the appropriate level of service is reimbursed.

Out Of Plan Referrals: These requests are reviewed individually, and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs.

Tertiary Care Services: All referrals to tertiary care centers are reviewed individually. The member's medical needs and the availability of the requested services within the non-tertiary care network are considered.

Predetermination Of Benefits/Outpatient Certification: Certain services, procedures, durable medical equipment, and injectable medications require prior authorization. Additionally, cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and/or members, to issue coverage determinations.

Transplant Evaluations: Paramount recommends working with a Paramount transplant case manager who will help determine the most appropriate Center of Excellence to refer members. Recommendations are based on cost and quality metrics, with the focus on achieving optimal outcomes for Paramount members. For this assistance, please contact Paramount's utilization management at 800-891-2520 or by email:
Commercial/Marketplace Case Management ParamountCommercialCaseManagement@medmutual.com
Medicare Case Management ParamountEliteCaseManagement@medmutual.com

Section 5: Behavioral Health

Prior Authorizations

Medicare Advantage And Commercial Plans

Please reference our prior authorization list for current information.

Hospital Inpatient And Observation Admissions

Paramount will review all hospital admissions for appropriateness and medical necessity. Paramount requires clinical notification of an inpatient stay by the end of the next business day following the admission. This includes elective admissions. Generally, the hospital pre-certifies or certifies inpatient admission. The physician's office may also pre-certify an admission.

- Non-Participating Facilities are required to prior authorize observation stays.
- Participating Facilities do not need to prior authorize observation stays.
- Pre-established medical necessity/appropriateness criteria are utilized to assure consistency in the certification process.

Please send the admission fact sheet with the patient's demographic information along with a clinical review. Please include contact information on the fax (name of facility UM reviewer, fax, and telephone number). Fax is the preferred method of communication (toll free: 844-282-4901).

InterQual® Behavioral Health Criteria Sets are the basis for all determinations of medical necessity; these include child, adolescent, adult, and geriatric psychiatry; adult and adolescent substance abuse.

If an admission is approved, the Behavioral Health UM Coordinator assigns a length of stay, based upon diagnosis, presenting signs and symptoms, investment in treatment, support system, and/or other factors as delineated in InterQual criteria.

- The admission is re-reviewed at appropriate intervals prior to discharge, or until the member no longer meets inpatient criteria. The Behavioral Health UM Coordinator will identify the next expected review date.
- Authorization of the admission includes all physician and ancillary services rendered during the inpatient stay.
- Excluded are those services that are not a covered benefit, such as convenience items.

A retrospective chart review is performed after the patient is discharged from the facility.
This type of review is necessary when Paramount i.e., the Behavioral Health team is not informed of the member's admission while he or she is inpatient (when the member does not present correct insurance information at time of admission, for example), or when the member has been admitted and discharged during a time outside of regular business hours, such as on a weekend or holiday.

Outpatient Services

The Behavioral Health Coordinator facilitates, and coordinates as needed, the appropriate use of benefits and referrals to all participating behavioral health providers including the publicly funded community behavioral health system i.e., community mental health centers (CMHCs).

Members may self-refer to all behavioral health providers including the agencies previously described. Certain Intensive outpatient services require prior authorization approval. Please reference Paramount's document library for the most current Behavioral Health resources, prior authorization requirements and forms.

The member has no liability (i.e., may not be billed) when a contracted/participating provider provides a covered service that requires prior authorization (for example, hospital admission), but for which the provider has not obtained required authorization.
The member is responsible (i.e., may be billed) for payment of non-covered services, including:

- All/any copays and coinsurance.
- Non-covered services received, such as policy/contract exclusions.
- Court-ordered testing or court-ordered treatment that is not medically necessary, or that is not a covered benefit according to the plan.
- Employer-mandated testing or treatment not medically necessary or non-covered.
- Testing and treatment for learning disabilities.
- Treatment for non-acute conditions; conditions that are not treatable.
- Services received after benefit is exhausted.

Section 6: Quality Improvement (Qi)

Overview

It is inherent in Paramount's philosophy that quality improvement is not the responsibility of any single individual or department. Rather, it is the responsibility of each provider and employee under contract with Paramount.

Paramount's contracts specifically require that practitioners and providers cooperate with quality improvement activities to improve quality of care, offered services and member experience while also permitting use of practitioner performance data for qualitative and quantitative analysis.

We provide a formal ongoing process by which the Health Plan and participating providers utilize objective measures to monitor and evaluate the quality and safety of clinical and administrative services provided to members. A systematic approach is used to identify and pursue opportunities to improve services and resolve problems.

Paramount's Quality Improvement Program Is Grounded On Four Principles:

- **Process Management:** Exercising control over all efforts through a systematic process of 'Plan, Do, Study and Act.
- **Management By Fact:** Managing all efforts through quantitative and quantitative analysis of data.
- **Respect For People:** Listening to and supporting others.
- **Customer Satisfaction:** Meeting or exceeding valid customer expectations.

Our Program Objectives:

- To continuously improve the caliber and delivery of clinical and administrative services to Paramount customers through systematic monitoring of critical performance indicators, identifying barriers to improvement, and implementing specific strategies to improve processes and outcomes.
- To assess annually the efficiency and effectiveness of the quality improvement program, including its structure, methodology, and results.
- To assess at least annually the efficiency and effectiveness of performance from any subcontracted agents or service providers, also known as delegated entities.
- To ensure all members are treated with dignity and respect, they are given appropriate, understandable education and information to accept responsibility and participate in personal health care decisions.
- To use evidence-based guidelines as the basis for all clinical decision-making.
- To support public health goals, as appropriate for the populations served, by integrating them into clinical quality improvement activities.
- To maintain regulatory compliance related to Paramount quality assurance and performance improvement activities.
- To cultivate comprehensive patient safety practices among Paramount providers and staff, including coordination of care.
- To identify disparities in health care delivery to members and intervene to reduce them by delivering culturally and linguistically appropriate care and services.

Quality Measures

Practitioner And Provider Requirements

Physicians, non-physician practitioners, hospitals, ancillary facilities, and all other types of health care providers contracting with Paramount are expected to maintain optimal levels of quality in their practice or service. The Physician Affairs Council sets performance expectations for participating physicians, defines network composition and panel size, and exercises peer review for contract compliance and practice performance. Measurable performance indicators are established during contracting with some health care provider organizations. Coordination of services among all practitioners and providers across and between health care settings is monitored and supported through various mechanisms.

Health Care Effectiveness Data & Information Set (HEDIS®)

HEDIS® is a growing set of performance and outcome measures originally developed in response to employers' need to compare health plans, now serving as the industry standard. Through detailed specifications for deriving these measures, HEDIS® provides commonly accepted methods for evaluating and trending health plan performance. Although several measures are captured as a hybrid of claims data and medical record reviews, most are collected as administrative-only data from claims, enrollment records and supplemental data files such as lab results. Annual measurement results are used for many internal and external performance indicators as described throughout the QI (QUALITY IMPROVEMENT) Work Plan and Evaluation.

To generate, manage, and submit HEDIS® data, Paramount utilizes NCQA-certified software. Paramount capitalizes on highly skilled QI department staff to abstract electronic and paper records for hybrid measures directly into the laptop-loaded application. Collaboration with many providers (such as ProMedica Laboratory) enables Paramount to download clinical test results as a supplemental file. The reporting process and results undergo a rigorous external audit by an NCQA-approved auditor each year. Data are then submitted to NCQA for each of Paramount's accredited product lines.

CMS uses patient experience scores to calculate a star rating for Medicare Advantage (MA) plans. This system allows consumers to compare health plans on a range of metrics for quality, performance, network benefits, costs, and patient experience. CAHPS (Consumer Assessment of Health care Providers and Systems) now comprises approximately 35% of each Medicare health plan's star rating. A subset of both the Commercial and Medicare CAHPS survey measures is also a component of the NCQA publicly reported Health Plan Ratings (HPR) system which distinguishes excellence among plans for health care consumers.

Star Rating

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system.

CMS Goals For The Five Star Rating System

- Implement provisions of the Affordable Care Act.
- Clarify program requirements.
- Strengthen beneficiary protections.
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers.

A Medicare Advantage (Mapd) Plans Star Rating Is Based On Measures In Eight (8) Categories:

- Staying Healthy: Screenings, Tests and Vaccines.
- Managing Chronic (Long Term) Conditions.
- Ratings of Health Plan Responsiveness and Care.
- Member Complaints, Problems Getting Care, Choosing to Leave the Plan.
- Health Plan Customer Service.
- Drug Plan Customer Service.
- Member Experience with the Drug Plan.
- Patient Safety and Accuracy of Drug Pricing.

The CMS Medicare Star Ratings Systems Benefits Both Providers and Members/Patients.

Benefits to providers:

- Improved patient relations.
- Improved health plan relations.
- Increased awareness of patient safety issues.
- Greater focus on preventive medicine and early disease detection.
- Strong benefits to support chronic condition management.

Benefits to Members:

- Improved relations with their doctors.
- Greater health plan focus on access to care.
- Increased levels of customer service.
- Greater focus on preventive services for peace of mind, early detection, and health care that matches their individual needs.

Clinical Practice Guidelines

The Clinical Guidelines for Physicians can be viewed and printed by physicians and physician offices from the Paramount website. These guidelines are evidence-based and intended for use as a guide in caring for Paramount members. The Medical Advisory Council reviews and approves each guideline annually. The guidelines are adopted from various nationally recognized sources such as the American Diabetes Association; the American Academy of Family Practice; the American Academy of Pediatrics; the National Heart, Lung, and Blood Institute; and the Agency for Health care Research and Quality.
The guidelines do not cover every clinical situation and are not intended to replace clinical judgment.
Should you have questions or require additional information, contact Paramount at: PHCQuality@MedMutual.com

Population Health (Condition Management) Overview

Sometimes taking care of a chronic health condition can be overwhelming for patients. That is what our population health team is here for.

We use a holistic health approach to assess the physical, psychosocial, behavioral health, nutritional, environmental, and lifestyle issues affecting our members. We promote wellness to encompass each whole person, and not just the chronic condition(s) they are living with.

Paramount's population health services amount to higher quality care, reduced medical costs, and more satisfied and empowered members who experience a better quality of life.

Our population health specialists are experts in managing the following:

- Asthma.
- Chronic kidney disease (CKD).
- Chronic heart failure (CHF).
- Chronic obstructive pulmonary disease (COPD).
- Depression.
- Diabetes.
- Migraine headaches.
- Post-cardiac events.
- Reproductive health.

We help members manage chronic conditions by offering personalized and compassionate support. Our team is made up of the following health care experts:

- Physician advisors.
- Pharmacists.
- Registered nurse health educators.
- Care management representatives.

An individualized condition-specific action plan is developed for each identified member. This plan includes management strategies and educational resources. For example, their personal plan may help them to:

- Adopt proper diet and exercise habits.
- Decrease the number of missed work and/or school days.
- Follow a smoking cessation plan.
- Identify symptom-causing triggers and learn how to avoid them.
- Interpret personal blood pressure readings, laboratory results and goals.
- Reach personal goals by following an individual treatment plan.

Our team also works with members to:

- Increase the use of appropriate medications.
- Improve medication and treatment plan adherence.
- Increase vaccinations and preventative screenings.
- Reduce improper use of the emergency room.
- Decrease hospitalizations.
- Decrease unnecessary health care costs.
- Prevent or delay disease problems and complications.

How It Works

Members are identified for our program through an algorithm and classified into risk categories every month. All identified members receive some type of intervention and reminders about important tests and appointments. Those at greatest risk receive higher-touch interventions.

You may also locate additional information at https://www.paramounthealthcare.com/providers/ condition-management

The following activities encompass our population health program:

- Comprehensive phone calls from a health educator to evaluate, assess and follow-up with members who are at higher risk.
- Case management evaluation and services for members at the highest risk and/or experiencing an acute illness.
- Deviceless remote condition monitoring.
- Pharmacy services, educational mailings, condition-specific newsletters, community forums, web- based interactive tools, and online support.

Section 7: Pharmacy

Prescription Drug Coverage

Commercial And Marketplace Exchange

Paramount Insurance Company provides prescription drug coverage through a network of pharmacies, in cooperation with our pharmacy benefits manager, CVS Caremark. Paramount offers Employer Group (Commercial) plans, Paramount Marketplace (Exchange) plans, multiple employer welfare arrangement (MEWA) plans, and Alliance Small Group plans.

Members may call Paramount Member Services or access CVS Caremark's website at Caremark.com to find participating pharmacies. These types of pharmacy benefits cover many generic drugs, preferred brand drugs, certain over-the-counter medications, and some medical supplies when a prescription is provided to the member. Select this link to find our lists of covered drugs, including restrictions and preferences (also called a formulary).

Commercial and Exchange Members with Paramount pharmacy benefits can fill up to a 30-day supply of non-specialty medications at participating retail pharmacies. A 90-day supply of non-specialty medications may be filled through either CVS mail-order pharmacy or CVS retail pharmacy locations.

Some members have a Maintenance Choice pharmacy benefit. These members are allowed two 30- day fills of a Maintenance Choice medication at a participating retail pharmacy of their choice before they must fill for a 90-day supply through CVS mail order or a CVS retail pharmacy.

Please also note that even though a commercial plan may have medical coverage, not all commercial plans have their prescription coverage through Paramount.

Medicare Advantage (Paramount Elite)

Prescription drug coverage is provided through Paramount Elite in cooperation with our pharmacy benefits manager, CVS Caremark. Members may call Paramount Member Services or access our website to find the list of covered drugs (called a drug formulary) and participating pharmacies.

The Paramount Elite Prescription Drug plan covers many generic drugs and preferred and non-preferred brand drugs. Each of these drugs is listed in our formularies under one of five cost-sharing tiers. For more information, see our Plan Documents and Information.

Prior Authorizations And Exceptions

Commercial And Marketplace Exchange

Prior authorization will be required for some prescription drugs such as non-formulary requests, specialty medications, and step therapy. For more information regarding prescription drug utilization management protocols, please click here to visit our website.

Prescription drugs on the prior authorization list will need to be reviewed and authorized through Paramount. If you have questions about the prior authorization process, please call us at 800-891-2520 option 2.

Additionally, pharmacy benefit prior authorization requests may be submitted electronically via CoverMyMeds.com. Prior authorization criteria are also available on this website.

Medicare Advantage (Paramount Elite)

A prescription drug may have restrictions such as clinical prior authorization, quantity limits, step therapy or Part B vs Part D. If a drug is not on the list of covered drugs, a member/provider can request a formulary exception. Additionally, a member/provider may request a formulary drug (excluding drugs on the specialty tier or Tier 5) at a lower cost sharing which is referred to as a tiering exception.
For more information and forms, see our Plan Documents and Information.

For Medicare prescription drug plans, prior authorizations and exceptions are reviewed by CVS Caremark. Please call 855-344-0930 or fax 855-633-7673. The information can also be submitted electronically. Links are located under Medicare Part D Electronic Submission on our website.
Please see our Plan Documents and Information.

Specialty Drugs And Specialty Network

Specialty drugs are prescription drugs that treat complex conditions such as multiple sclerosis, cancer, hepatitis, and rheumatoid arthritis. They can be self-administered and often require special handling or monitoring. Most of these drugs also require prior authorization. These drugs are available through a limited pharmacy network called the Specialty Network.

For more information, please review the corresponding formulary for any medications designated as Tier 5.

Infusions/Injections

Most provider-administered injections/infusions will be covered under medical benefits, with prior authorization reviews handled by Prime Therapeutics, LLC. However, injectable drugs may be covered under medical or pharmacy benefits. Most self-injections will be covered under the prescription benefit, and applicable prior authorization reviews will be handled by Paramount. Self-injectables are often limited to our specialty pharmacy network and require prior authorization.

Medicare Part D Vaccines

Adult Part D plan-covered vaccines are covered at a $0 member cost share through all Part D coverage stages. For a list of Paramount Part D plan covered vaccines, please refer to the plan formularies.

There are two parts to Paramount's coverage of Part D vaccines.

- Cost associated with the vaccine itself
- Cost associated with vaccine administration

If covered persons receive the vaccine in the provider's office, they will be responsible for the entire cost of the vaccine, including the administration fee. A covered person can then submit a reimbursement request (see Submission of Coverage Determinations section for additional information).

- A covered person will be reimbursed the amount he or she paid, less normal coinsurance or copayment, less any difference the provider's office charges and what Paramount normally pays.

Medicare Part B Drugs

Medicare Part B typically helps Medicare beneficiaries with their medical costs and does not provide prescription drug coverage. There are, however, some limited circumstances when medications are covered under the Part B benefit. This coverage does not apply to specific medications but rather to the treatment of certain diseases.

The coverage of drugs under Part B did not change after the implementation of Medicare Part D. Drugs that were covered by Part B remain covered by Part B and are excluded from coverage under the Part D benefit. The drugs covered by Part B typically fall into the following categories:

- Some vaccines (flu and pneumonia)
- Drugs that are treated as a supply to durable medical equipment (DME)
- Drugs furnished incident to a physician's service (e.g., provider "buy and bill")
- A limited number of self-administered drugs that are covered under Part B by Medicare regulations (e.g., immunosuppressive drugs for covered persons with Medicare-covered organ transplants, certain oral anti-cancer drugs, hemophilia clotting factors)

For prescription drugs dispensed at the pharmacy, Express Scripts will either adjudicate the claim at the point of sale (pharmacy) if sufficient information is available or indicate that a coverage determination review is required. Drugs provided incident to a physician's service will follow the same authorization and claim procedures as other physician services.

Please note that drugs covered under Part B will not follow the same copayment structure identified for Part D drugs.

Step Therapy for Part B Drugs

Paramount Health requires review of some medical benefit drugs (primarily injectables and biologics) for step therapy requirements in addition to other policy and review requirements for Medicare Advantage members. Corporate medical drug policies reflect these requirements and are available on the Paramount Health provider portal at paramounthealthcare.com/providers, Policies and Standards, then Medical Drug Management.

Step therapy does not apply to members who are already receiving active treatment with a non-preferred drug and is administered in accordance with all guidance from The Centers for Medicare & Medicaid Services (CMS).

Medicare Advantage members subject to step therapy requirements have the right to ask for an exception, or to appeal a request that was denied due to step therapy requirements

For more information, including how to request a prior authorization through Prime Therapeutics, refer to this page on our website. Click here.

To submit a medical drug prior authorization request to Prime Therapeutics, please visit PRIME THERAPUTICS or call 800-327-3974.

Limited Medical Supplies

Commercial/Exchange

Certain medical supplies are covered for Paramount Commercial members through the prescription drug benefit, including diabetic supplies and spacers for inhalers. Most members may currently choose whether to obtain these supplies at a preferred Durable Medical Equipment (DME) supplier under
the medical benefit or at a network pharmacy through their pharmacy benefit (if the member has prescription drug coverage through Paramount). Prior authorization is required for continuous glucose monitors and insulin pumps.

Refer to the formulary drug lists for details regarding which specific products are covered.

Medicare Advantage

Certain medical supplies (alcohol swabs, gauze pads, insulin pen devices and insulin syringes) are covered for Paramount Elite Medicare members through the prescription drug benefit and certain diabetic supplies (lancets and device, blood testing strips and blood glucose monitoring units) through the medical benefit and my require prior authorization.

Over-The-Counter Drug Coverage

Commercial

Coverage of over the counter (OTC) medications will vary depending on employer benefit structure. When coverage is available, medications are limited to products on the formulary drug list. Some examples of categories that may be covered include:

- Smoking cessation (Nicotine replacement products including gum, patches, lozenges).
- Low-dose aspirin.
- Folic acid.

Some employer groups exclude coverage of classes with high OTC availability (e.g., PPIs, Nasal Steroids, Antihistamines).

Marketplace Exchange

Coverage of a limited number of OTC medications is available. Covered medications are limited to products on the formulary drug list. Some examples of categories that may be covered include:

- Smoking cessation (Nicotine replacement products including gum, patches, lozenges)
- Low-dose aspirin.
- Folic acid.
- Contraceptive products covered under the Affordable Care Act (ACA) are preventive.

Medicare Advantage

CMS approved items are available for Medicare Advantage members on their Nations OTC account. Members may access the Nations portal at Paramount.Nationsbenefits.com/login or contact a representative at 877-204-1721 (711)

Drug Formulary

Commercial

Commercial members and providers can view which drugs are covered under their pharmacy benefit using the commercial preferred drug lists. For more information on the commercial preferred drug lists, please click here to visit our website.

Marketplace Exchange

Exchange and ACA/Small Group members and providers can view which drugs are covered under their pharmacy benefit on our website. Exchange members use the Health Insurance Marketplace Drug List and ACA/Small Group members use the ACA/Alliance Drug List. For more information on the Exchange preferred drug lists, please click here to visit our website.

MS-DRG and Geometric Mean Length of Stay (GMLOS)

DRGs are classifications of diagnoses and procedures in which patients demonstrate similar resource consumption and length-of-stay patterns. Each MS-DRG is assigned a geometric mean length of stay (GMLOS). This information is published in the MS-DRG table (Table 5) of the CMS annual IPPS Final Rule. To ensure accurate DRG assignment, correct coding, and appropriate reimbursement, Paramount conducts DRG clinical validation reviews both pre-payment and post-payment. When a facility's reported length of stay (LOS) significantly deviates from the published GMLOS for the assigned MS-DRG, the DRG assignment may be adjusted and may result in a payment reduction or denial.

Reporting an NDC on a CMS-1500 Claim Form

Drug products are assigned a unique 10-digit, 3-segment number by the U.S. Food & Drug Administration (FDA). This number, known as the National Drug Code (NDC), identifies the labeler, product, and trade package size. The NDC will be in one of the following configurations: 4-4-2, 5-3-2, or 5-4-1.

Medical claims, however, require the NDC to be converted to an 11-digit number in a 5-4-2 format, without any hyphens.

Converting NDCs from 10-digits to 11-digits (NDC 5-4-2 format):

10-Digit Configuration	Actual 10-Digit Example	11-Digit Conversion Example (hyphens are for illustration purposes only)
4-4-2	0002-7597-01	**0**0002-7597-01
5-3-2	50242-040-62	50242-**0**040-62
5-4-1	60575-4112-1	60575-4112-**0**1

Use Item 24 to report a National Drug Code (NDC) on a CMS-1500 Claim Form.

- NDC unit of measures must be reported.
- Use ME to report Milligrams.
- Valid CPT/HCPCS code(s) and NDC identifiers must be entered on the claim form. If the NDC does not have a specific CPT/HCPCS code, assign the appropriate miscellaneous code per Centers for Medicare and Medicaid correct Coding Guidelines.
- **You cannot bill more than one NDC per service line.**
- For electronic claims, the NDC qualifier (N4), NDC Code (5-4-2 format, no hyphens), NDC Quantity and Unit of Measure are submitted in the 2410 loop.

Medical Drug Management

National Drug Codes

Paramount requires that National Drug Code (NDC) identifiers be submitted on all professional and outpatient claims when billing for all medications and diabetic supplies. This will allow us to process medical drug claims and avoid delays in provider reimbursement more efficiently.

Affected claims must have a valid Healthcare Common Procedure Coding System (HCPCS) code and NDC identifiers, which include the 11-digit drug code (5-4-2 format), quantity of medication dispensed and unit of measure.

Billing for Discarded Drugs

Paramount requires the modifier JW on claims submission for drugs and biologicals supplied in single-use packages (including single-use vials) that are appropriately discarded. The modifier JW describes a drug amount discarded or not administered to a patient. The modifier is necessary for processing claims for single-use packages of drugs subject to Paramount's prior authorization process.

The modifier JW ensures the patient received the dosage approved during the prior authorization process. It also ensures providers are reimbursed appropriately for the entire single-use package.

When billing for drugs and biologicals supplied in single-use packages, report the amount discarded on a separate line with the modifier JW added to the associated Healthcare Common Procedure Coding System (HCPCS) code. This process will provide payment for the discarded drug or biological in cases when the administered drug is a covered benefit.

The modifier JW may not be submitted when the actual dose of the drug or biological administered is less than the billing unit. For example:

- One billing unit for a drug is equal to a 10mg of the drug in a single-use vial.
- A provider administers a 7mg dose to a patient and discards the remaining 3mg of the drug.
- The provider bills the 7mg dose using one billing unit that represents 10mg on a single line item
- Paramount will process the single line item of one unit for payment of the total 10mg of drug administered and discarded.

Billing another unit on a separate line item with the JW modifier for the discarded 3 mg of drug is not permitted because it would result in overpayment. Therefore, when the filling unit is equal to or greater than the total actual dose and the amount discarded, HCPCS modifier JW may not be submitted.

Paramount expects that, in addition to the amount of drug or biological administered to the patient, provider's document in the patient's medical record:

- The date the drug is discarded
- The time the drug is discarded
- The amount of drug discarded
- The reason for the drug being discarded

A provider cannot bill for discarded drugs if not administered to a patient (for example, in the case of a missed appointment). In addition, the amount billed as discarded cannot be administered to another patient.

The Company expects providers to use the most cost-effective vial of drug when procuring and preparing a dose for administration and reimburses accordingly. The JW modifier cannot be used for drugs or biologicals administered from multi-use packages. Paramount does not pay for waste associated with multi-use packages.

Paramount will deny claims not submitted as requested above.

Billing for Single-Dose Vial Drugs

Paramount requires the JZ modifier on claims submission for drugs and biologicals supplied in single-dose containers (including single-use vials) and there are no discarded amounts. The JZ modifier is a HCPCS Level II modifier reported on a claim to attest that no amount of drug was discarded and eligible for payment. The modifier should only be used for claims that bill for single-dose container (including single-use vial) drugs. The modifier is necessary for processing claims for single-dose containers of drugs subject to Paramount's prior authorization process.

When a billing provider or supplier administers a drug from a single-dose container/vial and there are no discarded amounts, the provider or supplier must file a claim with one line for the drug. For the administered amount, the claim line should include the billing and payment code (such as HCPCS code) describing the given drug, the JZ modifier (attesting that there were no discarded amounts), and the number of units administered in the units' field.

The JZ modifier is to be reported on UB-04 and CMS-1500 claims. The JZ modifier does not apply for drugs that are not separately payable, such as packaged OPPS or ASC drugs. The JZ modifier is not required for vaccines.

Effective October 1, 2025, Paramount will deny claims not submitted as requested above.

Billing Modifiers JA and JB

For claims involving drugs that are usually administered via infusion, the correct modifier must be included:

- **JA** – Use when the drug is administered **intravenously**.
- **JB** – Use when the drug is administered **subcutaneously**.

Important: Claims submitted without the appropriate JA or JB modifier may be rejected

Section 8: Medicare Advantage

Medicare and Medigap Plans

Overview

Medicare is available for those who are 65 and older, or for those who have certain disabilities and qualify for Medicare coverage before turning 65. Today, we offer Medicare Advantage plans branded as Paramount Elite Medicare.

Our Medicare Advantage plans are available to people who have Medicare Part A and Part B, also known as Original Medicare. We cover all Original Medicare benefits, but offer coverage for prescription drugs and other enhancements, such as dental, hearing, vision, wellness incentives and meals.

Key facts about Paramount Medicare Plans:

- More than 17,000 members.
- More than 1,000 Medicare Medigap members.
- 96%-member retention rate.
- Paramount Elite is available in select counties in Ohio, Michigan, Kentucky, and Indiana.
- Highly rated plan.

Member Enrollment And Eligibility

Overview of Plans

- Part A | Hospital Coverage: Hospital insurance that covers inpatient hospital stays, skilled nursing facility care and hospice care.

- Part B | Medical Coverage: Medical insurance that covers select doctor services, outpatient care, certain medical supplies, and preventive services, but does not cover prescriptions.

- Part C | Medicare Advantage Preventive and Coordinated Care: The preventive and coordinated care of this plan covers Part A and Part B benefits, plus may include additional coverage for prescriptions or vision and is offered through private insurance providers.

- Part D | Prescription Drug Coverage National Network: Covers prescription drugs.

- Medicare Supplements (Medigap): If members have Original Medicare Parts A and B – the Medicare plan offered by the Federal government; they can add Medicare supplemental insurance to help cover the gaps in Original Medicare coverage. Paramount offers five supplemental (Medigap) plans. These plans are called Medigap.

Supplemental insurance fills “gaps” in Original Medicare. We offer a variety of Medigap plans that allow members to enjoy comprehensive coverage with greater protection in the event of an unexpected illness or injury.

Eligibility

To be eligible for Paramount Elite Medicare plans you must live in one of the following counties: OH-Adams, Allen, Ashland, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Crawford, Cuyahoga, Darke, Defiance, Erie, Fayette, Fulton, Geauga, Greene, Hamilton, Hardin, Henry, Highland, Huron, Lake, Lorain, Lucas, Madison, Medina, Mercer, Miami, Montgomery, Ottawa, Paulding, Portage, Preble, Putnam, Sandusky, Seneca, Shelby, Summit, Van Wert, Warren, Wayne, Williams, Wood, Wyandot MI-Branch, Hillsdale, Lenawee, Monroe, Washtenaw. IN-Adams, Allen, DeKalb, Dearborn, Franklin, Noble, Ohio. KY-Boone, Campbell, Kenton. Members can contact a licensed insurance agent at 877-715-7044 if they have questions about their eligibility, enrollment periods or exceptions.

Enrollment

Annual Enrollment Period (AEP): Members may enroll in a Medicare Advantage plan with or without prescription drug coverage during the annual election period. The AEP is from Oct. 15 through Dec. 7 of every year.

Medicare Advantage Open Enrollment Period (OEP): During the Medicare Advantage Open Enrollment Period, members are permitted to make one change from one Medicare Advantage plan to a Paramount Elite plan, if they would like to.

Newly Eligible for Medicare Benefits: The Initial Election Period (IEP) is the period when members are first eligible for Medicare Parts A and B and can enroll in a Medicare Advantage plan. Generally, their Initial Enrollment Period for Part D is at the same time.

For example, if a member is eligible for Part B when they turn 65, their IEP is the seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.

If members have questions, they should contact our Member Services department toll-free at 833-554- 2335 (TTY 711) Monday – Friday from 8 AM – 8 PM.

Additionally, between October 1st and March 31st both Member Service lines are available seven days per week between 8 AM and 8 PM.

Member ID Card

A Paramount Elite Medicare Plan ID card is mailed to each member when they join one of the plans. Members will use their Paramount Elite Medicare card instead of their red, white, and blue Medicare card.

Our members are reminded to keep their card with them always and to present it each time they receive medical services.

Plan year 2025 member ID cards (below) will be the only ID cards received.

Member Welcome Materials

New Medicare members are mailed a new member packet. Their member packet includes:

- Welcome letter.
- Medicare confirmation of enrollment letter.
- Resource guide: This is a yearly resource mailed to members to help them understand their benefits and resources available to them.
- Wellness Booklet that highlights important information to share with your PCP and other helpful tips.

Member Rights And Responsibilities

Paramount Medicare members have certain rights and responsibilities. Please review the document on our website.

Member Notification of Network Changes

When a participating provider contract has been voluntarily or involuntarily terminated, we follow a procedure to ensure that members are notified within the specified timeframe.

The following CMS guidelines must be followed: Chapter 4, 110.1.2.3 - "Notification to Enrollees" (Rev. 121, Issued, 04-22-16, Effective: 04-22-16, Implementation 04-22-16).

If notified in advance, member services will make a good faith effort to notify affected members by letter at least 30 days before termination of a provider's contract. If notified after the provider has left their practice, member services will notify affected members within one business day.

Member Services

Interpreter Services

As a provider, you are required by federal law to provide language assistance when requested, or when you believe it will ensure a satisfactory health care encounter. You are responsible for providing effective communication services to communicate with your patient.
Please remember:

- You are prohibited from requiring that a patient provide their own interpreter.
- The service must be free to the patient.
- It is never acceptable to involve a minor child in health care interpreting.
- If a patient wants to bring his/her own interpreter, it is recommended you also arrange for a qualified medical interpreter.

We offer free aids and services to members with hearing and visual Impairments, or Limited English Proficiency (LEP). These include:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as, information written in other languages.

Interpreting is primarily conducted over the phone but can also be face-to-face or video link depending on location. Sign language interpreting can take place on-site or through an electronic video link.
Telecommunication Relay Service is available to persons with Text Telephone (TTY) equipment. Translation, unlike oral interpretation, can convert written information from one language to another.

To arrange for these services, please contact Medicare Member Services at 833-554-2335 and MAP Medicare Member Services at 833-585-3388. We will automatically update the member's record.

Member Services Call Center

Our Medicare member services' call center is available to answer member questions, including what services are covered, how to access services, how to find a provider, file a complaint, change their PCP, access language assistance, and more. It is a priority for our members to be satisfied with all aspects of the services they receive.

Member services can be reached by calling Medicare Member Services at 833-554-2335 (TTY 711), Monday – Friday, 8 AM – 8 PM. (excluding holidays). From Oct. 1 through March 31, we are available 8 AM to 8 PM. seven days per week.

Member services can also be reached via email at:

- For Paramount Elite, please email Paramount.Memberservices@MedMutual.com.
- We are closed Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving Day, and Christmas Day. If the recognized holiday occurs on a Saturday, member services will be closed on the preceding Friday. If the recognized holiday occurs on a Sunday, member services will be closed on the following Monday.

Personal Call Center Representative

By signing up, members will speak to the same person in member services every time they call.

Live Chat

Paramount Elite members have access to Live Chat - a quick, safe, and secure way for members to reach our member services team with questions. Live Chat Is available to members Monday through Friday, 8 AM - 5 PM.

Online Member Portal

Members can stay well connected to their health plan through the MyParamount Portal.

Member Programs

Annual Physical Exam

Members receive an annual physical exam with their primary care provider at a $0 copay. Also, they continue to receive their annual wellness visit at no cost.

Medicare members have the chance to receive a $50 wellness incentive by completing two preventive screenings annually, as recommended by their doctor.

Dental Benefit

Paramount Elite Medicare plans offer dental benefits for our members. Included in all our Medicare plans, the dental benefit will cover preventive and comprehensive dental services that are not covered by Original Medicare.

Preventive Dental Services

Covered Preventive/Diagnostic Dental Services

- 2 periodic oral exam(s) per calendar year: Oral Exams are limited to two exams of any procedure type (periodic oral exam/limited (D0120), problem focused (D0140)/comprehensive oral (D0150)/periodontal evaluation (D0180)) per calendar year. Services must be provided at a participating in-network dental provider.
- 2 preventive cleaning(s) (D1110) per calendar year.
- Up to 4 (one-set) bitewing dental X-ray(s) (D0270-D0274) per calendar year.
- 2 fluoride treatment(s) (D1206/D1208) per calendar year: Fluoride Treatment includes topical application of fluoride varnish or topical application of fluoride – excluding varnish.

Covered Diagnostic And Comprehensive Dental Services (Coverage And Limits May Vary By Plan)

- Diagnostic Services: Intraoral evaluations (D0220/D0230) are limited to three evaluations within
- any consecutive 12-month benefit plan year period. Complete series (D0210) or Panoramic (D0330) of radiographic images covered are limited to 1 per 5 years.
- Restorative Services: Amalgam (D2140-D2161) and Resin based composites (D2330-D2394) are limited to one procedure per tooth every 3 years. Crown services are not covered by all plans.
- Endodontics: Endodontic Therapy (D3310/D3320/D3330) is limited to one procedure per tooth per lifetime.
- Periodontics: Periodontic scaling (D4341/D4342) and root planning procedures require submission of supporting documentation and subject to Utilization Review. Must contain 4 teeth with 4+MM pockets. These procedures are covered every 3 years. Periodontic Maintenance (D4910) is covered 2 per benefit plan year.
- Extractions (D7140/D7210): Unlimited visits.
- Other Oral/Maxillofacial - Surgery Services (D7220-D7250): Prosthodontics are covered under this plan effective 1/1/2024.
- Additional Benefits: Plan benefit also includes incisional biopsy of oral tissue (D7286). Tele dentistry visit (D9995 real-time synchronous encounter) with Dental provider covered twice per benefit plan year. Palliative (emergency) treatment of dental pain – minor procedure (D9110).

Orthodontics are not covered under our plans.

In network benefits for covered procedures are provided at 100% of allowable fees and 70% for out of network on most plans.

Hearing Benefit

We offer our Medicare members a hearing aid benefit through NationsHearing®, making addressing hearing loss more affordable. Members experience the latest advances in technology, and personalized care. To learn more and schedule an appointment, members can call 877-204-1721, Monday through Friday from 8 AM to 8 PM.

Meal Benefit

When it is time to go home after an inpatient hospital or skilled nursing facility stay, there are so many things to worry about and plan. We provide our Medicare members with two meals a day for 14 days after each discharge from an inpatient or skilled nursing stay – at no cost to them up to a maximum of 28 days per calendar year.

Over The Counter (OTC) Benefit

Our OTC benefit is in partnership with NationsOTC®. Our benefit offers members an effortless way to shop for brand and generic items, over-the-counter health and wellness products and have them shipped directly to their home. They will receive our OTC Catalog and a Benefit card in the mail to be utilized at a network of retail locations. Members will have up to a $100 per quarter allowance to use. Any unused allowance does not roll over to the next quarter.

Silver Sneakers®

Our partner Tivity Silver Sneakers® brings Medicare members a fitness membership at no additional cost. With more than 15,000 locations across the United States and classes for every fitness level, they will find an activity they love.

Wellness Incentives

Members can earn a $50 wellness incentive by taking care of their health. All they need to do is have their wellness visit and complete two preventive health services.
Preventive screenings include:

- Basic metabolic or lipid panel
- Colorectal screening
- DEXA scan
- Flu vaccine
- Mammogram
- Pneumonia vaccine

For members with a diagnosis of diabetes, they can earn a second incentive by completing two of the following services for a $30 incentive:

- HbA1c testing
- Diabetes eye exam
- Nephropathy screening
- Diabetes self-management training

Worldwide Coverage

No matter where adventures take our Medicare members, their plan goes with them. The coverage includes no copays for emergency care services, urgent care services and emergency ambulance outside of the United States.

Additional Medicare Advantage Guidelines

Billing for Non-Covered Services

Providers must not bill Medicare for services that are not covered under the applicable Local Coverage Determination (LCD) as if they were covered. When submitting claims for non-covered services, the appropriate modifier must be used:

- **GA** – Use when an Advance Beneficiary Notice (ABN) was issued as required and the item/service is expected to be denied as **not reasonable and necessary**.
- **GX** – For **Part A** claims, use when a voluntary ABN is issued for a service that is **statutorily excluded** or **not a Medicare benefit**.
- **GY** – For **Part B** claims, use when the item/service is **statutorily excluded** or does **not meet the definition of any Medicare benefit**.
- **GZ** – Use when **no ABN was issued**, and the item/service is expected to be denied as **not reasonable and necessary**.

Section 9: Commercial/Marketplace

Commercial Overview

For businesses that are looking to offer health insurance coverage to their employees, Paramount works with large and small employers to create health plans that best meet their needs. Our commercial plans are sold to employers in northwest Ohio and southeast Michigan.
Paramount Commercial Quick Facts:

- More than 72,000+ members.
- More than 1,200 employer groups.
- 96.6% of our clients renew with Paramount for their employee health insurance every year.
- 97%-member retention rate.
- 75th percentile ranking.
- Consumer Assessment of Health care Providers and Systems (CAHPS) is a ranking of our member experience and overall ranking of our health plan.

Member Enrollment and Eligibility Overview of Plans

- **Health Maintenance Organization (HMO):** A Paramount HMO is a cost-effective health insurance plan for members, sponsored by their employer. We have HMO plans available for large and small groups; both fully funded and self-funded. HMO plans are available in Ohio.

- **Preferred Provider Organization (PPO):** Paramount's PPO plans give a little more freedom of choice and flexibility to members. It includes a larger network of health care providers for more access, and free benefits and services, such as full coverage of preventive services. Paramount's PPO plans are available to groups of two or more people located in Michigan and to self-funded groups in Ohio.

- **Consumer Directed Health Plan (CDHP):** Paramount's CDHP plans work to lower costs and increase awareness of health care costs. A CDHP may be accompanied by a Health Savings and/or reimbursement account or may be a high-deductible plan. CDHP is available in both Michigan and Ohio.

- **Point Of Service (POS):** Paramount POS plans combine attributes from both HMO and PPO plans, yet smaller deductible for most care and lower copays when compared to PPO and CDHP plans. POS plans available In Michigan and Ohio.

- **Administrative Services Only (ASO):** Available to self-funded employers a solution to controlling costs and managing risk, based on the employer's specific needs. ASO plans are available in both Michigan and Ohio.

- **Medical Home:** Program available to large groups only. The Medical Home program rewards members and providers for working together to achieve better health and wellness.

- **Multiple Employer Welfare Arrangement (MEWA):** Paramount has partnered with Northwest Ohio Business Alliance (NOWBA) to create fully funded plans for businesses with 50 or fewer employees. MEWA is available in Ohio.

- **Short-Term Health Plans:** Paramount Short-Term Health Plans are available in four policy durations – 3 months, 6 months, 9 months, and 364 days or less. Short-term plans use Paramount's HMO network and are available in northwest Ohio.

Enrollment

Member enrollment in health insurance through their employer depends greatly on when their employer establishes the enrollment period. However, for most groups, this happens in late fall because their employees' coverage begins on the first of the New Year.

Member ID Card

A Paramount ID card is mailed to each member when they join Paramount. Our members are reminded to keep their card with them always and to present it each time they receive medical services.

Member Welcome Materials

- Welcome letter: Paramount will mail members a welcome letter, brochure that highlights key benefits and their member ID card.
- Member handbook: Explains their member's benefits in detail. The member handbook is available online. Member Handbooks

Member Rights and Responsibilities

Paramount commercial members have certain rights and responsibilities. Please review the document on our website.

Member Termination Procedure

When a participating provider contract has been voluntarily or involuntarily terminated, Paramount follows a procedure to ensure that members are notified within the specified timeframe.

According to ***OAC §3901-8-1, (F) "Notice"***, the issuer must provide notice of the expiration or termination of a provider or facility from the issuer's network to an enrollee who has received health care services within the previous 12 months.

Notification must be provided as follows:

- Within fifteen business days of the effective date of the expiration or termination of a provider or facility from the issuer's network; or
- If the issuer is not aware of the expiration or termination of a provider or facility from the issuer's network prior to it taking effect, notice must be given within fifteen business days of the issuer becoming aware of such change.

An issuer is deemed to be aware of the expiration or termination of a provider or facility from the issuer's network if the issuer:

- Receives notification related to such change from a provider or facility.
- Takes any action with respect to the provider or facility, such as adjudicating or processing claims, which demonstrates that there is a change in the provider or facility's network status.

Member Programs and Services

As a Paramount member through their workplace, their insurance coverage will depend on their employer's choice of plans. However, many of the items listed below are available to them.

Nurse Line

Ask Paramount, our free nurse line, is available toll-free, 6:00am to midnight, 7 days a week, 365 days a year. Our experienced registered nurses stand ready to answer health-related questions and concerns. They can also help members figure out if they need to schedule an appointment with their primary care provider, visit an urgent care clinic or go to the emergency room.
To talk with an Ask Paramount nurse, members can call toll-free: 877-336-1616.

Summary Of Benefits and Coverage

The Summary of Benefits and Coverage (SBC) shows the member exactly how services are covered - what their copay, deductible or coinsurance is. They can view their specific benefits in the myParamount.org portal.

Dependent Child Coverage

For HMO plan members, Paramount's dependent child program expands coverage for member's dependent child while they are residing outside of Paramount's service area. Out-of-area coverage includes emergency, urgent and follow-up care services, and prescriptions (drug rider required).

Marketplace Exchange Plans

Marketplace plans allow those who do not have access to health insurance to shop and enroll in health coverage through the federal government's health exchange or may shop individual state's marketplace plans. Paramount's Marketplace plans are an example of marketplace coverage throughout the state. Marketplace plans offer a higher level of comprehensive coverage compared to a short-term plan.

Member Enrollment and Eligibility

Overview Of Plans

Paramount has eight plans to choose from with varying levels of benefits for both individuals and families.

- **Gold Plans:** Paramount's Gold Plans are for members who expect to use a lot of health care services within the next year. Preventive services are covered in full. Many services are not subject to deductible.
- **Silver Plans:** Paramount's Silver Plans are for members who wish to save on premiums, while keeping out-of-pocket costs low. Preventive services are covered in full. Many services are not subject to deductible. Cost sharing subsidies are available, if applicable.
- **Bronze Plan:** Our Bronze Plan offers a balance between monthly premiums and out-of-pocket costs. Like the Gold and Silver Plans, preventive services are fully covered.

Eligibility

To be eligible for health coverage through the Paramount Health Insurance Marketplace:

- Members must reside in one of the following northwest Ohio counties: Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood, or Wyandot.
- Members must be a U.S. citizen or national (or be lawfully present).
- Members must not currently be incarcerated.
- Members' eligible dependents must be under the age of 26.

Enrollment

To enroll, members can visit our online open enrollment portal.

Special Enrollment Period

Members may qualify to purchase Paramount coverage outside of the annual open enrollment periods if they have experienced a Qualifying Life Event, such as a change in residence, a change in jobs, or if they got married, divorced, or had a baby in the past 60 days. To find out if they meet the Qualifying Life Event criteria, they can call us at 800-462-358.

Summary Of Benefits And Coverage

The Summary of Benefits and Coverage (SBC) shows the members exactly how services are covered - what their copay, deductible or coinsurance is. They can view their specific benefits in the MyParamount.org portal.

Wellness Incentive

Members can earn a $50 Visa gift card through our Wellness Incentive by taking care of yourself. Members need to complete the following by the end of the coverage year: Schedule your annual wellness visit and get your flu shot.

- 360,000 claims are processed annually.
- 3,000 proprietary in-network dentists.
- More than 95,000+ dentists nationwide with 190,000+ access points to dental care in our network.

Section 10: Compliance

HIPAA Requirements and Information

To ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) (45 CFR Part 160 and Subparts A and E of Part 164), one must first understand the definition of Protected Health Information (PHI), which is the foundation upon which the rules are based. PHI is information that is created or received by a health care provider and is related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. PHI also either identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI pertains to both living and deceased individuals. There are defined rules for 'de-identifying' data, so it does not contain PHI. But, generally, if one person can determine the identity of the member/ patient or to whom the information applies, and the information was inappropriately disclosed, a HIPAA violation has likely occurred.

Paramount maintains the privacy of members' PHI in the strictest confidence and takes the responsibility very seriously. Paramount is fully committed to complying with all federal and state laws regarding the privacy and security of members' PHI. Paramount holds all providers, both contracted and non- contracted, to these same standards. Paramount expects providers to respect the privacy of Paramount members and ensure their PHI is safeguarded.

Duties of Providers

Providers are required to maintain and respect the privacy of Paramount's members. Paramount provides members with a Notice of Privacy Practices upon enrollment and annually thereafter. This notice explains how Paramount will use member's information. This notice can be found on our website. Please click here. Paramount expects providers to abide by the notice as it applies to their interactions with Paramount's members.

Providers should be cognizant of the additional protections afforded to Paramount's members pursuant to 42 CFR Part 2 regulations. These requirements provide additional protections around substance use disorder treatment information and add other requirements to health care providers. Additionally, while HIPAA provides the floor for regulatory protections to member's privacy rights, many states have additional protections for PHI. Providers are required to comply with all state and federal regulations.

Uses and Disclosures of PHI

The use and disclosure of member and patient PHI, without the proper written authorization, or as required by law, is restricted to that which is necessary to carry out treatment, payment, or health care operations (TPO) activities. Uses or disclosures for purposes other than TPO activities require a written authorization.

Written Authorizations

The use and disclosure of member and patient PHI is not permitted or required under applicable law requires the authorization of the patient or their legally authorized representative. The Authorization must meet HIPAA and applicable state law requirements. Paramount's HIPAA-compliant authorization can be found on our website. Please click here.

Unintentional Disclosures

In the rare circumstance where Paramount may inadvertently disclose Paramount member PHI to a provider who was not the intended recipient, Provider shall immediately notify Paramount of this mistaken disclosure. The provider shall maintain the privacy of the information and either return or
securely destroy the information. The provider agrees to not use or further disclose the information. The provider agrees, upon Paramount's request, to supply Paramount with an attestation verifying the return, destruction, and non-disclosure of any inadvertently disclosed PHI.

Cybersecurity

Pursuant to state and federal law, providers are required to maintain technological safeguards to assure patient and member data is adequately protected. These safeguards must meet criteria specified
in both HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). Providers should be aware of any potential theft of financial or medical data and report the same to Paramount immediately upon discovery. These discoveries can lead to additional investigations of fraud, waste, and abuse.

Stark I, II & III

Prohibits physicians from referring Medicare patients to a hospital or other entity for the provision of "designated health services" if the physician or immediate family member has a financial relationship with that entity unless an exception exists. Financial relationships are defined as both ownership/ investment interests and compensation relationships. Designated health services include physical, occupational, and speech therapy, clinical laboratory services, radiology services (including MRI, CAT scans, and ultrasound services), radiation therapy, durable medical equipment, orthotics and prosthetic devices, home health services, Parenteral and enteral nutrients and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services. Paramount expects that all providers will abide by these federal requirements. Upon discovery of a violation of these regulations, Paramount will report suspected providers to the appropriate state and/or federal entity.

Anti-Kickback

Medicare Anti-Kickback statutes make it a crime for a person (i.e., a physician) to knowingly and willfully solicit or accept payment (or other remuneration) for referring a patient to another person/entity for the furnishing of any item or service for which payment may be made (in whole or in part) by the Medicare or programs. The statute also makes it a crime to knowingly and willfully offer or pay remuneration to "induce" such a referral. An "inducement" is any act intended "to exercise influence over the reason or judgment of another to cause the referral or program-related business." As with the Stark regulations, Paramount will report suspected providers to the appropriate state and/or federal entity.

False Claims Act

The False Claims Act (FCA) includes both civil and criminal provisions used in enforcement of the law, which makes it an offense for any person/entity to present false claims to the United States government. The elements necessary to establish a civil FCA violation are: 1) presentation of a claim,
2) to the United States government or any program funded by the government and 3) actual knowledge that the claim is false/fraudulent or with reckless disregard or deliberate ignorance of the truth or
falsity of the claim. As Paramount has both Medicare and commercial lines of business, Paramount's investigative efforts often implicate potential FCA violations. As such, violations will be reported to the appropriate regulatory body.

Antitrust Compliance

Antitrust laws apply to almost all industries, including health care. These regulations prohibit a variety of agreements and conduct, which could restrain a competitive industry. The federal government is responsible for enforcing the federal antitrust laws, and state Attorney Generals are responsible for enforcing the state antitrust law in their respective state. Federal and state governments investigate and pursue organizations suspected of being in violation. Violation of these statues can result in significant losses through financial penalties and criminal sanctions. Paramount abides by these requirements and expects all providers to do so as well. Any request for information which could violate these regulations will be denied and repeated requests will be reported as suspected anticompetitive behavior.

Compliance Hotline

If you recognize an actual or possible violation of laws, rules, or regulation, Providers may report it to Paramount using Paramount's Compliance Hotline at 1-800-553-1000.

Paramount's Compliance Hotline is available 24 hours per day, seven days per week, 365 days per year. Reports to the Compliance Hotline may be made anonymously. All information received is kept confidential. Paramount has a strict non-retaliation policy to protect Providers and others who report problems and concerns in good faith.

When reporting, please remember to include the names of all applicable parties involved and provide as much information as possible so that Paramount can investigate your report. If possible, please include your name and telephone number so we may contact you if we have any questions during our investigation.

Fraud, Waste and Abuse (FWA)

Introduction

Health care fraud, waste, and abuse (FWA) is a national problem that affects all of us either directly or indirectly. National estimates project billions of dollars are lost to health care FWA on an annual basis. These losses lead to increased health care costs and potential increased costs for coverage. Providers, members, and taxpayers can be harmed when this occurs.

Paramount is committed to conducting its business operations in compliance with ethical standards, internal policies and procedures, contractual obligations, and all applicable federal and state statutes, rules, and regulations. Paramount's commitment to guard against FWA extends to its oversight and monitoring responsibilities related to its contracted entities.

Definitions

Health Care Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Health Care Waste is overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to any health care benefit program. Waste is generally not considered caused by criminally negligent actions but by misuse of resources.

Health Care Abuse includes actions that may directly or indirectly result in unnecessary costs to any health care benefit program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence among other factors.

Mission And Goals of Paramount's FWA Program

The mission of Paramount's Fraud Waste and Abuse Program is to protect the integrity of Paramount, along with federal and state programs by actively detecting, preventing, investigating, and reporting suspected cases of FWA. The goals of Paramount's FWA Program are to:

- Detect, prevent, investigate, and report incidents of FWA.
- Implement internal policies and procedures to accomplish the mission and to mitigate the risk for recurrence.
- Report instances of substantiated FWA to the appropriate government agencies and/or law enforcement.
- Cooperate fully with all investigations of FWA conducted by government agencies and/or law enforcement.
- Prevent and/or recover payments lost to fraudulent, wasteful and/or abusive billings; and,
- Provide communication and education regarding FWA.

Examples of Healthcare FWA

By Members:

- Allowing someone else to use his/her member identification card to receive medical care, medications, supplies, or equipment, etc.
- Changing prescription form to get more than the amount of medication prescribed by their physician.
- Agreeing to let a health care provider bill Paramount for services he/she never received.
- Misrepresenting a medical condition to obtain services.
- Knowingly providing false information (wrong date of birth, address etc.) on enrollment forms.

By Providers:

Not billing according to the American Medical Association ("AMA"), American Association of Professional Coders ("AAPC") and/or Centers of Medicare and Medicaid Services ("CMS"):

- Billing for services, procedures, or supplies that have not been rendered.
- Billing for equipment, drugs, or services that are not medically necessary.
- Billing for procedures not appropriate for the diagnosis on the claims lead to additional and/or higher reimbursement.
- Billing for services outside of your designated specialty.
- Billing for a place of service or location other than where the service was rendered to obtain a higher reimbursement level.
- Unbundling claims to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Routinely submitting duplicate claims.
- Inappropriate use of modifiers in billing to obtain a higher level of reimbursement.
- Altering claims and/or medical records to obtain a higher level of reimbursement.

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- Prescribing high quantities of controlled substances without medical necessity.
- Upcoding (using procedure or diagnosis codes that pay at a higher rate).
- Overutilization – billing for services not medically necessary to obtain a higher level of reimbursement.
- Underutilization – failing to provide our members with services that are medically necessary.
- Receiving kickbacks for referrals.

By Pharmacies:

- Billing multiple payers for the same prescription.
- Billing for non-existent prescriptions.
- Billing for brand drugs when generics are dispensed.
- Billing for an item not dispensed.
- Shorting prescription drugs.
- Splitting prescriptions into multiple orders to get higher reimbursement.
- Dispensing expired, diluted, or tainted prescription drugs.

By Vendors:

- Billing for services not rendered or products not received.
- Billing for more expensive services while performing a less expensive service.

By Workforce Members:

- Misrepresenting facts to deny or approve benefits.
- Obtaining kickbacks for referrals.
- Creating a fictitious provider to pay false claims.
- Forging a member's signature for enrollment purposes.
- Misrepresenting benefits.
- Impersonating a government employee.
- Behaving in an unethical or dishonest manner while performing company business.

Response and Reporting of FWA

Any suspected case of FWA is to be reported promptly upon identification to Paramount's Financial Investigations Department within the Compliance Office. All information received is strictly confidential. Paramount's Compliance Hotline is available 24 hours per day, seven days per week, 365 days per year. Reports to the Compliance Hotline may be made anonymously. Please notify Paramount if you suspect any health care fraud, waste, or abuse by using the following resources:

- Providers may call the Paramount Compliance Hotline at 1-800-553-1000 to report suspected FWA.
- Sending a letter with any pertinent information to:
  Paramount Health Care
  Attn: Financial Investigations
  100 American Road
  Cleveland, OH 44144

Paramount has a strict non-retaliation policy to protect Providers and others who report problems and concerns in good faith. All reports are investigated.

When reporting suspected fraud, please remember to include the names of all applicable parties involved. Specify which person(s) you believe is committing fraud, identify the dates of service, and/or issues in question and describe in detail why you believe a fraudulent act may have occurred.

If possible, please include your name and telephone number so we may contact you if we have any questions during our investigation.

Prepayment Fraud, Waste and Abuse Detection Activities

Paramount may initiate a prepayment review of a provider on behalf of a regulatory agency or Paramount. When this occurs, Paramount may pend claims and require Provider to produce supporting documentation (medical records, progress notes, etc.) for submitted claims to validate the information contained on the claims, especially billed charges, is appropriate. If the documentation is not received from Provider, or not received in a timely manner, all claims will be denied until records and other supporting documentation are received.

Paramount's claims payment system is designed to audit claims thoroughly to detect and stop claims before payment is inappropriately sent to Provider. Within the claims process, Paramount performs multiple pre-payment claim audits by incorporating edits within the claims system. Examples of those edits include but are not limited to:

- Post Service Claim Edits to check for appropriate information for specialty drugs billed on Medical Claims.
- Correct Coding Initiative (CCI) edits basic and includes clinical reviews.
- CMS Bundling edits.
- Centers for Medicare and Medicaid Services (CMS) guidelines.
- American Medical Association.
- National Coverage Determinations.
- Other editing for correct coding – examples – global billing, duplicates, MUEs (Medically Unlikely Edits), and modifiers.
- Clinical coding review of medical records for appropriateness.

Post-Payment FWA Claims System Audits

Paramount performs additional post pay claims audits such as auditing of DRGs paid on claims. Paramount also reviews the Office of the Inspector General List of Excluded Individuals and Entities, the Government Services Administration Excluded Parties list, FDA Exclusion List, and state exclusion lists to assure members and contracted entities have not been excluded from participating in a federal program. Additionally, Paramount has a dedicated unit of investigators who audit and monitor the service patterns of providers, members, and vendors. The Financial Investigations Department routinely monitors claims and medical records identifying anomalies, which may lead to further concentrated investigations. Upon findings of suspected fraud, waste, or abuse, corrective actions may be taken.
Corrective actions can include:

- Member disenrollment
- Cooperation with law enforcement
- Education of member or provider
- Reporting to state/government regulatory agencies, as applicable.
- Recovery of overpaid funds
- Provider Contract termination

Claims Audits

Paramount's Investigators may perform telephonic audits, desk audits, announced onsite audits, and unannounced onsite audits. If onsite audits are requested by Investigators, the investigator should be given a space to work in and all documentation requested on the day of the audit. Upon completion of the audit, if overpayments have occurred, Provider agrees to repay funds promptly or Paramount may seek recoupment for overpayments realized by Provider. The provider must provide the investigator, during normal business hours, with access to examine, audit, scan and copy all records necessary to determine compliance and accuracy of billing.

In the event a Paramount Investigator is unreasonably denied access to the Provider's records, all Claims for which Provider inappropriately received payment are due to be repaid to Paramount. If Provider fails to provide requested documentation to the investigator, the entire amount of the claim is to be immediately refunded to Paramount. In each of the cases, Claims are no longer reimbursable to Provider. Paramount reserves the right to offset the full amount of the claim against any amounts owed to Provider. Provider must produce requested records to Paramount without charge, timely, and in the manner requested.

Pursuant to HIPAA (45 C.F.R Part 160 and Subparts A and E of Part 164), Provider agrees Paramount is entitled to the requested information under the "payment" exception. Provider agrees Paramount is also entitled to conduct investigations and audit records to verify services were performed both before payment is issued and after payment is dispensed pursuant to HIPAA and a variety of other federal and state regulations and agreements.

Paramount agrees to use established industry claims adjudication and/or clinical practices, state, and federal guidelines and/or Paramount policies and data to determine which claims should be investigated and reviewed and to formulate conclusions during the investigation. The provider agrees to cooperate with Paramount's Special Investigations Unit during any audit and/or investigation of claims by providing access to all requested documentation at reasonable, agreed upon times. Failure to provide requested information in a timely manner may result in any number of punitive actions up to and including termination of the Provider's agreement, recoupment of funds paid, and reports made to state and federal entities.

During the review process, Paramount reserves the right to review a random sample or smaller subset of a larger group of data to formulate an estimate of the impact of the issue identified. The error rate identified during this review may be projected across all claims to determine the total amount of overpayment.

Audit Provisions

The Company reserves the right to audit specific claim payments on an individual or aggregate basis, regardless of whether such payment or payments have already been made, and may make retroactive adjustments to such claims payments, for reasons including the following, without limitation:

- Medical necessity or lowest cost setting determinations
- Bill/claim validation determinations of coding accuracy
- Fragmentations pursuant to the Agreement
- Adjustments required for failure to comply with submission of claim instructions or requirements of the Company
- PRES/SDS/POES billing for outpatient claims if another inpatient or outpatient claim has been submitted
- Billing for Serious Reportable Events

Requests for medical records, itemized bills, and other documentation are sent to providers as part of audits. A claim may be retroactively denied if the provider does not supply the requested documentation to determine correct processing. If the requested documentation is received within 60 days post denial, the denial will be reversed and the claim reviewed for accuracy. This record denial reversal is not a guarantee of payment. Records received after this 60-day grace period will not be reviewed and the claim will be finalized through technical denial.

Robotic Surgical Systems

Reimbursement for utilization of a robotic surgical system (including, but not limited to, HCPCS code S2900 and applicable ICD-10-PCS codes) included in the payment for the primary procedure. No additional payment will be made when charges associated with robotic surgery are billed, including but not limited to, increased or additional operating room charges for the use of robotic surgical systems.

MS-DRG and Geometric Mean Length of Stay (GMLOS)

DRGs are classifications of diagnoses and procedures in which patients demonstrate similar resource consumption and length-of-stay patterns. Each MS-DRG is assigned a geometric mean length of stay (GMLOS). This information is published in the MS-DRG table (Table 5) of the CMS annual IPPS Final Rule. To ensure accurate DRG assignment, correct coding, and appropriate reimbursement, Paramount conducts DRG clinical validation reviews both pre-payment and post-payment. When a facility's reported length of stay (LOS) significantly deviates from the published GMLOS for the assigned MS-DRG, the DRG assignment may be adjusted and may result in a payment reduction or denial.

Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

Paramount follows the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)*. If, after reviewing a member’s medical record for a claim submitted with a sepsis and/or severe sepsis ICD-10-CM code, Paramount determines that sepsis and/or severe sepsis was not a valid diagnosis and/or not present on admission based on Sepsis-3 criteria, the diagnosis-related group (DRG) claim assignment may be adjusted accordingly with the appropriate DRG claim assignment had a sepsis and/or severe sepsis ICD-10-CM code not been billed and that is supported by the member’s medical record.

*Mervyn Singer, MD, FRCP; Clifford S. Deutschman, MD, MS; Christopher Warren Seymour, MD, MSc; et al. “The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).” JAMA. 2016;315(8):801-810.

Global Leadership Initiative on Malnutrition (GLIM)

Paramount follows the Global Leadership Initiative on Malnutrition (GLIM) criteria for malnutrition. If, after reviewing a member’s medical record for a claim submitted with a Mild protein-calorie malnutrition, Moderate protein-calorie malnutrition, Unspecified protein-calorie malnutrition, or Unspecified severe protein-calorie malnutrition ICD-10-CM code, Paramount determines that malnutrition was not a valid diagnosis and/or not present on admission based on GLIM criteria, ICD-10-CM coding guidelines, and AHA Coding Clinic guidance, the diagnosis-related group (DRG) claim assignment may be adjusted accordingly with the appropriate DRG claim assignment had malnutrition not been billed and that is supported by the member’s medical record.

Jensen GL, Cederholm T, Correia MITD, et al. (2019) GLIM Criteria for the Diagnosis of Malnutrition: A Consensus Report From the Global Clinical Nutrition Community JPEN J Parenter Enteral Nutr, Vol 43 (1) 32-40; ICD-10-CM Official Guidelines for Coding and Reporting; AHA Coding Clinic

Post-Payment Recoveries

This section of the Provider Manual is hereby incorporated into the Provider Agreement and supplements, rather than minimizes, rights and remedies available to Paramount under the Provider Agreement, at law or equity.

Should the terms herein and the terms of the Provider Agreement conflict, the parties to the Provider Agreement concur Paramount, in its sole discretion, shall exercise the terms expressed in the Provider Agreement, the terms herein, rights under law and/or equity, and/or some combination thereof.

Upon request, the Provider will give Paramount, regulatory agencies, and any representatives thereof access to request and review all documentation related to claims and/or Paramount members that are required to support compliance with the Provider agreement. Information that may be requested by Paramount investigators includes but is not limited to:

- Medical Records.
- Progress Notes.
- Member COB (Coordination of Benefits) information.
- Member Information.

All items must be shared timely and as requested. If records are not received from Provider as requested, Paramount will begin a process of offsetting future claims or processing recoupments.

Provider/Practitioner Education

During an audit and investigation, if Paramount determines a provider has not billed services appropriately, Paramount may choose to educate the provider either onsite, by email, by phone, or onsite at their office. Upon completion of the initial Provider/Practitioner education, a corrective action plan may be required from the provider so that there is a documented plan for improvement. Further audits may occur in the future to verify claims submitted by the Provider are appropriately coded and billed as well as complete.

Medical Record Documentation Standards

The Clinical Quality Improvement Department:

- Educates the provider community regarding nationally recognized standards for confidentiality, medical record documentation, organization and accessibility, and availability of patient appointments through displays on the Company website and articles in Company newsletters.
- Performs random medical record keeping reviews to assess provider compliance to these standards. These medical record keeping reviews use criteria that are consistent with widely accepted national quality and regulatory standards. The Company uses two different sets of documentation standards, with one set directed toward medical/surgical providers, while the other set is designed for behavioral health specialists. These standards as well as sample intake sheets are available at MedMutual.com/Provider, Resources, Continuity and Coordination of Care.

Medical Record Guidelines and Considerations

A highlight of medical record guidelines and considerations is listed below:

Medical Record Documentation

- Medication allergies and adverse reactions are prominently noted in the medical record. The absence of any known allergies must be likewise prominently noted in the medical record.
- Past medical history is easily identified and includes serious accidents, operations and illnesses. Past medical history for children should relate prenatal care, birth information, operations and childhood illnesses.
- Assessment for the presence of depression or alcohol abuse/dependence is performed and the nationally recognized tool used in this assessment is documented.
- Notation concerning use of tobacco, alcohol and substances is present for patients who are age 11 and older. Thereafter, an annual query for tobacco usage is documented.
- Current medications and dosages are prominently displayed.
- Consultation, lab and imaging reports are contained within the patient record.
- Significant illnesses and medical conditions are indicated on a problem list.
- Each and every page in a medical record contains the patient's name or identification number.
- The medical record is legible to someone other than the writer.

Plan of Care

- A patient's history and physical exam documents appropriate subjective and objective information for presenting complaints.
- Working diagnoses are consistent with findings.
- Treatment plans documented are consistent with diagnoses.
- Provide and document appropriate child and/or adult preventive services and risk screenings.

Advance Directives

- Beginning at age 18, prominently document the existence of a patient's advance directive.
- Store the advance directive in a consistent and prominent location in the patient's medical record.

Medical Record Standard (Paper)

- Medical record is organized to facilitate easy retrieval of patient information.
- Medical record is stored to permit easy retrieval.
- Medical record is secured out of public access.
- Historical medical records are stored to permit easy retrieval during normal business hours.

Medical Record Standard (Electronic)

- Patient health information and data are readily available to the practitioner.
- Security of the patient's health information and data is maintained.
- Test ordering and results are organized and managed in the system.
- Reminders, prompts and alerts are used to support decision-making activity.

Confidentiality

- A confidentiality statement is signed by all staff.
- Office staff receives periodic training in the confidentiality of patient information.

Patient Rights and Responsibilities

- The office has a written policy that demonstrates they do not discriminate in the delivery of healthcare services.

Appointment Accessibility

- See the Availability Goals and Accessibility Standards sub-section of this section for the list of Provider Accessibility Standards.

Office Site Standards

A highlight of the office site standards is listed below.

- Rooms and floors are clean and uncluttered.
- Corridors leading to exits are clear.
- Storage areas are separate from exam rooms.
- One exam room is present for each provider.
- Adequate waiting areas are present with adequate seating.
- Waiting room is well lit.
- Office hours are posted.
- Handicap parking is available, or a written alternative plan is present.
- Wheelchair access/ramp to the office is present or a written alternative plan is present.
- Minimal or no-hands access entry to the building is available or a written alternative plan is present.
- All office doors are wide enough for wheelchair access or a written alternative plan is present.
- Handrail assist is present in patient restrooms or a written alternative plan is present.

Behavioral Health Treatment Record Documentation Standards

The Clinical Quality Improvement department:

- Educates the provider community regarding nationally recognized standards for confidentiality, medical record documentation, organization and accessibility, and availability of patient appointment accessibility through displays on the Company website and articles in Company newsletters.
- Performs random medical record keeping reviews to assess provider compliance of these standards. These medical record keeping reviews use criteria that are consistent with widely accepted national quality and regulatory standards. The Company uses two different sets of documentation standards, with one set directed toward medical/surgical providers, while the other set is designed for behavioral health specialists. These standards as well as sample intake sheets are available at MedMutual.com/Provider, Resources, Continuity and Coordination of Care.

Treatment Record Guidelines and Considerations

A highlight of the Behavioral Health Treatment Record Standards is listed below:

Treatment Record Documentation

- Medication allergies and adverse reactions are prominently noted in the medical record. The absence of any known allergies must be likewise prominently noted in the medical record.
- Each and every page in a medical record contains the patient's name or identification number.
- The medical record is legible to someone other than the writer.
- Personal/biographical data includes: date of birth, address, employer, home and work telephone numbers, emergency notification name and number, and marital status.
- Current medications and dosages are prominently displayed.
- Patient's past mental health history is documented.
- Patient's past medical history is easily identified.
- Assessment for the presence of depression or alcohol abuse/dependence is performed and the standardized tool used in this assessment is documented.
- Notation concerning current and past use of tobacco, alcohol and substances is present for patients who are age 11 and older. Thereafter, an annual query for tobacco usage is documented.
- Patient's legal history is documented.
- Family mental health history is easily identified and includes any illnesses in family members.

Treatment Plan

- A patient's history and mental status exam documents information for presenting complaints.
- Working diagnoses addresses the five axes of DSM-IV and are consistent with findings.
- Treatment plans documented are consistent with diagnoses.
- Documented goals are measurable and behaviorally oriented with an estimated time frame for attainment.
- Interventions are consistent with the diagnosis.
- Appropriate consent form for communication is used.
- Detail evidence of continuity/coordination of care.

Treatment Record Standard (Paper)

- Treatment record is organized to facilitate easy retrieval of patient information.
- Treatment record is stored to permit easy retrieval.
- Treatment record is secured out of public access.
- Historical treatment records are stored to permit easy retrieval during normal business hours.

Treatment Record Standard (Electronic)

- Client health information and data are readily available to the practitioner.
- Security of the client's health information and data is maintained.
- Test ordering and results are organized and managed in the system.
- Reminders, prompts and alerts are used to support decision-making activity.

Confidentiality

- A confidentiality statement is signed by all staff.
- Office staff receives periodic training in the confidentiality of patient information.

Patient Rights and Responsibilities

- The office has a written policy that demonstrates they do not discriminate in the delivery of healthcare services.

Appointment Accessibility

See the list of Behavioral Health Accessibility Standards from the previous section. See the Availability Goals and Accessibility Standards sub-section of this section for the list of Provider Accessibility Standards.

Provider Office Site Standards

A highlight of the office site standards follows.

- Rooms and floors are clean and uncluttered.
- Corridors leading to exits are clear.
- Storage areas are separate from exam rooms.
- One exam room is present for each provider.
- Adequate waiting areas are present with adequate seating.
- Waiting room is well lit.
- Office hours are posted.
- Handicap parking is available, or a written alternative plan is present.
- Wheelchair access/ramp to the office is present or a written alternative plan is present.
- Minimal or no-hands access entry to the building is available or a written alternative plan is present.
- All office doors are wide enough for wheelchair access, or a written alternative plan is present.
- Handrail assist is present in-patient restrooms, or a written alternative plan is present.