for Elite Members

Healthways SilverSneakers Fitness Program is the nation’s leading wellness program, designed exclusively for Medicare beneficiaries. Beginning January 1, 2013, eligible members receive a basic fitness membership with access to amenities and fitness classes including the signature SilverSneakers classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination.

As an alternative for members who can’t get to a SilverSneakers participating location, SilverSneakers Steps is available. SilverSneakers Steps is a self-directed physical activity program that allows members to measure, track and increase physical activity doing activities of their choice. Steps provides the equipment, tools and motivation necessary for members to achieve a healthier lifestyle through increased physical activity. Eligible plan members may register for SilverSneakers Steps at www.silversneakers.com/member.

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Paramount • 1901 Indian Wood Circle • Maumee, OH 43537
www.paramounthealthcare.com
Preferred Brand Drug List Changes for 2013

The Pharmacy and Therapeutics Working Group, a subgroup of the Medical Advisory Council at Paramount, has reviewed and approved changes to the Preferred Drug List for commercial benefits. This Preferred Drug List only includes brand-name prescription drugs, which are available at the preferred-brand copayment level if a generic drug is not available. When a brand-name drug on this preferred list becomes generically available, the brand-name drug may no longer be offered at the preferred-brand copayment level. When a generic version of reasonable price becomes available, the brand-name version becomes a multisource brand and may no longer be covered or may be available at higher copayment levels.

2013 PDL Additions:
- Actoplus Met® XR - Diabetes
- Complera® - Antiviral
- Edurant® - Antiviral
- Epzicom® - Antiviral
- Intelence® - Antiviral
- Isentress® - Antiviral
- Lexiva® - Antiviral
- Prezista® - Antiviral
- Selzentry® - Antiviral
- Symlinpen® - Diabetes
- Xarelto® - Anticoagulant

2013 PDL Deletions:
- No deletions of drugs without therapeutic equivalents were made.

2013 PDL Deletions with Generic alternatives:
- Actoplus Met® - Diabetes
- Actos® - Diabetes
- Avalide® - Antihypertensive
- Avapro® - Antihypertensive
- Lexapro® - Antidepressant SSRI
- Plavix® - Hematological
- Singular® - Respiratory

Questions? Need a Full Preferred Drug List?
If you have any questions about your prescription drug benefit or would like a copy of the complete 2013 Preferred Drug List, call Member Services at 1-419-887-2525 or 1-800-462-3589. You can also visit the Paramount web site at www.paramounthealthcare.com. In the “Members” section, click on “Prescription Drug Benefits,” “Preferred Drug Lists,” and finally “2013 Commercial Preferred Drug List.”

Over-the-Counter (OTC) Updates
Prilosec OTC, Claritin OTC, Zyrtec OTC, Allegra OTC, and Prevacid 24HR continue to be covered for all Paramount Commercial members at the generic copayment level. A prescription is necessary for the pharmacy to process an approved OTC medication under your prescription benefit.
Paramount Member Satisfaction Results

Every year, Paramount measures members’ satisfaction with the quality of their care and services. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are conducted as part of our Healthcare Effectiveness Data and Information Set (HEDIS®) review. These surveys are important because they help us understand how we can provide our members with better care and service. They also enable us to judge how we compare with health plans across the nation. Again, this year, the results were strong. When compared to the national average, Paramount scored higher in five of eight measures. Paramount members rated How Well Doctors Communicate and Rating of Specialists in the top 25% of health plans nationally. Here’s how Paramount compares to the 2012 national averages in member satisfaction for Quality Compass®.

<table>
<thead>
<tr>
<th>CAHPS® 4.0H Measure</th>
<th>Commercial HMO 2012 Results</th>
<th>2012 HMO National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>84.76%</td>
<td>85.13%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>87.79%</td>
<td>85.85%</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>95.38%</td>
<td>93.86%</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>92.55%</td>
<td>90.60%</td>
</tr>
<tr>
<td>Rating of Health Care</td>
<td>79.66%</td>
<td>78.91%</td>
</tr>
<tr>
<td>Rating of Health Plan</td>
<td>68.83%</td>
<td>70.82%</td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>83.18%</td>
<td>84.89%</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>87.21%</td>
<td>83.77%</td>
</tr>
</tbody>
</table>

Accredited health plans significantly outperform non-accredited plans. Public disclosure of performance data and independent accreditation remain important expectations of both public- and private-sector purchasers. For these reasons, Paramount remains committed to public reporting by maintaining accreditation through the National Committee for Quality Assurance (NCQA) and achieving clinical performance results that compare favorably to national standards.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
** HEDIS® and Quality Compass® are registered trademarks of the NCQA.
HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that the public and health insurance consumers have the information they need to reliably compare the performance of managed health care plans. In combination, the results of NCQA CAHPS® and HEDIS® provide the most complete view of health plan quality currently available.

NCQA annually assesses and reports on the quality of the nation’s managed care plans through surveys and performance measurement programs. These programs are complementary, producing information that consumers, employers and government agencies can use to make informed decisions about health care. These activities overlap - to earn NCQA Accreditation, a health plan must report on its performance in a wide range of areas according to rigorous specifications, including member satisfaction, quality of care delivered by plan providers (preventive care, utilization and effectiveness of care), access and service.

Performance Counts
The HEDIS® Effectiveness of Care subset of measures are a good indication of how well our providers interact with their patients to deliver preventive health care. It also evaluates their effectiveness in coordinating appropriate care for chronic and acute clinical conditions, such as heart disease, diabetes, pharyngitis, and depression. HEDIS® results are compiled from administrative claims data and supplemented with medical record reviews on a random sample of over 6,000 charts and electronic health records.

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** HEDIS® and Quality Compass® are registered trademarks of the NCQA.

Safeguard in Utilization

Paramount’s utilization management decisions are based only on appropriateness of care and service and the existence of coverage. Utilization management staff and associate medical/clinical directors are not financially or otherwise paid to encourage under-utilization and/or denials of coverage or care. In fact, Paramount monitors and analyzes monthly reports for patterns of under-utilization and takes action to address any identified problems. In addition, nursing staff cannot deny services—denials can be made only by board certified, locally participating physicians.
Below are HEDIS® results for Commercial (HMO), Paramount Elite and Paramount Advantage compared to Paramount’s 2011 goals. Measures showing statistically significant improvement (p < 0.05) from the previous year are indicated with a †. A copy of the Quality Improvement and Utilization Management Program Evaluation can be requested by calling 419-887-2500 or by e-mail at phcquality@promedica.org.

<table>
<thead>
<tr>
<th>Effectiveness of Care Measure</th>
<th>Paramount HMO</th>
<th>Paramount Elite</th>
<th>Paramount Advantage</th>
<th>Paramount Goal (HMO/Elite/Adv)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Combo 2 (DTaP, OPV/IPV, MMR, Hib, Hepatitis B, VZV)</td>
<td>79.56%</td>
<td>Not applicable</td>
<td>64.72%</td>
<td>85% / 72%</td>
</tr>
<tr>
<td>Adolescent Immunizations</td>
<td>58.15% †</td>
<td>Not applicable</td>
<td>51.82% †</td>
<td>34% / 30%</td>
</tr>
<tr>
<td><strong>Cancer Screenings:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening (women ages 40-69)</td>
<td>69.15%</td>
<td>70.82%</td>
<td>45.16%</td>
<td>74% / 76% / 54%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (women ages 21-64)</td>
<td>81.42% †</td>
<td>Not applicable</td>
<td>78.72%</td>
<td>82% / 79%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (men &amp; women ages 50-80)</td>
<td>63.21% †</td>
<td>67.53%</td>
<td>Not applicable</td>
<td>60% / 67%</td>
</tr>
<tr>
<td><strong>Pregnancy Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of Prenatal Care (first trimester)</td>
<td>96.20%</td>
<td>Not applicable</td>
<td>92.52%</td>
<td>97% / 92%</td>
</tr>
<tr>
<td>Postpartum Care (at 21-56 days)</td>
<td>88.04%</td>
<td>Not applicable</td>
<td>71.03%</td>
<td>90% / 75%</td>
</tr>
<tr>
<td><strong>Cardiovascular Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure (&lt;140/90)</td>
<td>69.77%</td>
<td>64.15%</td>
<td>66.93%</td>
<td>68% / 70% / 66%</td>
</tr>
<tr>
<td>Persistent Beta Blocker Treatment After a Heart Attack</td>
<td>Not reportable</td>
<td>89.36%</td>
<td>Not reportable</td>
<td></td>
</tr>
<tr>
<td>Cholesterol Testing (annual)</td>
<td>81.51%</td>
<td>85.40%</td>
<td>78.26%</td>
<td>88% / 89% / 82%</td>
</tr>
<tr>
<td>Cholestrol Control (&lt;100 mg/dL)</td>
<td>56.93%</td>
<td>65.94%</td>
<td>47.83%</td>
<td>63% / 64% / 43%</td>
</tr>
<tr>
<td><strong>Comprehensive Diabetes Care:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c test (annual)</td>
<td>89.78%</td>
<td>93.19%</td>
<td>82.38%</td>
<td>93% / 94% / 84%</td>
</tr>
<tr>
<td>HbA1c poorly controlled (&gt;9.0%) (lower rate is better)</td>
<td>25.79%</td>
<td>14.36%</td>
<td>38.21%</td>
<td>≤24% / ≤15% / ≤35%</td>
</tr>
<tr>
<td>HbA1c controlled (&lt;8%)</td>
<td>61.80%</td>
<td>76.16%</td>
<td>51.36%</td>
<td>68% / 76% / 47%</td>
</tr>
<tr>
<td>Dilated eye exam (annual)</td>
<td>65.45%</td>
<td>88.08% †</td>
<td>66.25%</td>
<td>66% / 82% / 68%</td>
</tr>
<tr>
<td>Lipid test (annual)</td>
<td>80.78%</td>
<td>88.08%</td>
<td>67.25%</td>
<td>86% / 90% / 73%</td>
</tr>
<tr>
<td>Lipid Control (&lt;100 mg/dL)</td>
<td>47.69%</td>
<td>56.93%</td>
<td>31.27%</td>
<td>48% / 58% / 34%</td>
</tr>
<tr>
<td>Nephropathy screening/treatment (annual)</td>
<td>78.59%</td>
<td>88.08%</td>
<td>71.22%</td>
<td>84% / 94% / 77%</td>
</tr>
<tr>
<td>Blood Pressure Control (&lt;140/90)</td>
<td>70.07%</td>
<td>71.78%</td>
<td>70.97%</td>
<td>75% / 68% / 73%</td>
</tr>
<tr>
<td>Good Blood Pressure Control (&lt;140/80)</td>
<td>40.15%</td>
<td>55.23% †</td>
<td>42.43%</td>
<td>36% / 36% / 37%</td>
</tr>
<tr>
<td><strong>Behavioral Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness - Within 7 days</td>
<td>43.60%</td>
<td>32.26%</td>
<td>59.58%</td>
<td>64% / 35% / 57%</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness - Within 30 days</td>
<td>76.30%</td>
<td>67.74%</td>
<td>31.08%</td>
<td></td>
</tr>
<tr>
<td>Antidepressant Management - Acute Phase Medication Trial</td>
<td>62.26%</td>
<td>56.14%</td>
<td>45.50%</td>
<td>63% / 65% / 68%</td>
</tr>
<tr>
<td>Antidepressant Management - Effective Continued Drug Therapy</td>
<td>44.19%</td>
<td>42.69%</td>
<td>26.73%</td>
<td>47% / 48% / 48%</td>
</tr>
<tr>
<td>ADHD - Initiation of Follow-up Care</td>
<td>36.88%</td>
<td>Not applicable</td>
<td>49.25%</td>
<td>39% / 42%</td>
</tr>
<tr>
<td>ADHD - Maintenance of Follow-up Care</td>
<td>44.44%</td>
<td>Not applicable</td>
<td>54.35%</td>
<td>39% / 42%</td>
</tr>
<tr>
<td>Initiation of Treatment for Alcohol &amp; Other Substance Dependence</td>
<td>48.43%</td>
<td>50.00%</td>
<td>49.65%</td>
<td>45% / 55% / 47%</td>
</tr>
<tr>
<td>Engagement of Treatment for Alcohol &amp; Other Substance Dependence</td>
<td>17.31%</td>
<td>5.00%</td>
<td>18.83%</td>
<td>22% / 8%</td>
</tr>
<tr>
<td><strong>Respiratory Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Appropriate Medications for Asthma (ages 5-64)</td>
<td>92.97%</td>
<td>Not applicable</td>
<td>87.35%</td>
<td>94% / 93%</td>
</tr>
<tr>
<td>Spirometry Testing for COPD</td>
<td>41.61%</td>
<td>37.35%</td>
<td>35.85%</td>
<td>45% / 33% / 40%</td>
</tr>
<tr>
<td>Use of Systemic Corticosteroid for COPD</td>
<td>Not reportable</td>
<td>74.32%</td>
<td>Not reportable</td>
<td></td>
</tr>
<tr>
<td>Use of Bronchodilator for COPD</td>
<td>Not reportable</td>
<td>57.92%</td>
<td>Not reportable</td>
<td></td>
</tr>
<tr>
<td><strong>Appropriate Antibiotic Treatment:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children with URI</td>
<td>78.40%</td>
<td>Not applicable</td>
<td>77.36%</td>
<td>83% / 84%</td>
</tr>
<tr>
<td>Adults with Bronchitis</td>
<td>19.82%</td>
<td>Not applicable</td>
<td>17.92%</td>
<td>25% / 25%</td>
</tr>
<tr>
<td>Strep Testing for Children with Pharyngitis</td>
<td>68.39%</td>
<td>Not applicable</td>
<td>56.48% †</td>
<td>76% / 66%</td>
</tr>
<tr>
<td><strong>Other Preventive Care:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>57.91%</td>
<td>/ 60%</td>
</tr>
<tr>
<td>HPV Immunization for Adolescent Females</td>
<td>10.95%</td>
<td>Not applicable</td>
<td>16.79%</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening in Women (ages 16-24)</td>
<td>32.91%</td>
<td>Not applicable</td>
<td>52.79%</td>
<td>40%</td>
</tr>
<tr>
<td>Adult Flu Shots (survey question)</td>
<td>51.74%</td>
<td>71.90%</td>
<td>Not applicable</td>
<td>53% / 73% / 53%</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>64.23% †</td>
<td>72.51% †</td>
<td>56.93% †</td>
<td></td>
</tr>
<tr>
<td>Weight in Kids - BMI</td>
<td>50.12%</td>
<td>Not applicable</td>
<td>38.93% †</td>
<td></td>
</tr>
<tr>
<td>Weight in Kids - Nutrition Counseling</td>
<td>61.56%</td>
<td>Not applicable</td>
<td>46.72%</td>
<td></td>
</tr>
<tr>
<td>Weight in Kids - Activity Counseling</td>
<td>59.12% †</td>
<td>Not applicable</td>
<td>38.20%</td>
<td></td>
</tr>
<tr>
<td><strong>Imaging Studies for Back Pain</strong></td>
<td>79.35%</td>
<td>79.07% (1 year only)</td>
<td>64.72%</td>
<td>78% / 70% / 68%</td>
</tr>
<tr>
<td><strong>Advising Smokers To Quit (survey question/ 2-year average)</strong></td>
<td>71.25%</td>
<td>Not applicable</td>
<td>75.35%</td>
<td>74% / 78%</td>
</tr>
</tbody>
</table>
 Paramount Enhances Care by Offering In-home Assessments

Paramount has partnered with CenseoHealth to conduct in-home assessments on selected Paramount Elite members. A more complete and accurate picture can often be gained by going directly to the member with a targeted evaluation that fully documents that member’s health status. These evaluations also present an ideal opportunity to collect actionable information about the member’s care, driving better medical management.

Select Paramount Elite members are invited to take part in a 60 to 90 minute in-home assessment with a physician evaluator based on multiple factors, including medical history, the presence of multiple chronic conditions, and/or claims history which suggests they have not been routinely accessing their Primary Care Provider (PCP).

Members selected for the program receive a letter on Paramount Elite letterhead describing the in-home assessment program and how it can benefit them. CenseoHealth’s member outreach specialists will then contact these members to describe the program in greater detail, gain the members’ consent, and schedule the assessments. We ensure these Members understand that the in-home assessment does not replace the excellent care received from their primary care physician and is provided by Paramount strictly as an added benefit at no additional cost to them.

The physician evaluators use a proprietary evaluation tool that is not only pre-populated with member information, but also actually adapts itself to the clinical history of each member to ensure the most rigorous evaluation possible. Assessment providers review available information before their visit, including information about past chronic conditions. As part of the assessment, a comprehensive written evaluation is completed by the physician and made available to Paramount and the enrollee’s PCP. The member is also left with a written summary of the evaluation and follow-up recommendations.

Goals of the program include:

• Providing an additional touch point for members who have difficulty accessing their PCP.
• Assessing a member’s home environment and how it impacts their health care.
• Determining what routine screenings have been missed and should be considered, and encouraging members to discuss any recommendations with their primary care physician.
• Escalating any urgent or emergent clinical or social issues found at the time of the in-home assessment by working with the enrollee’s primary physician and/or the Paramount case management staff.
• Documenting all chronic conditions to ensure the network physician and the Centers for Medicare and Medicaid Services (CMS) have a comprehensive health status for the member.
• Collecting data to support the community physician and Paramount in maintaining certain quality indicators, such as HEDIS measures, as required by CMS.

This program is voluntary and does not affect an enrollee’s health-care coverage in any way.

If you have additional questions about this program, please contact your Provider Relations Representative.
# Paramount’s Access Standards

Access is defined as the extent to which a member can obtain available medical services when he or she needs them. Below are the expected access standards for general medical/surgical and behavioral health services provided by Paramount physicians and providers.

## MEDICAL / SURGICAL

### ROUTINE ASSESSMENTS, PHYSICALS OR NEW VISITS
- **PCP STANDARD**: 95% of members can access care within 30 days
- **NON-PCP STANDARD**: 95% of members can access care within 60 days

### ROUTINE FOLLOW-UP VISITS
- Recurring problems related to chronic conditions such as hypertension, asthma and diabetes.
- **PCP STANDARD**: 95% of members can access care within 14 days
- **NON-PCP STANDARD**: 95% of members can access care within 45 days

### SYMPTOMATIC NON-URGENT VISITS
- Examples include cold, sore throat, rash, muscle pain, and headache.
- **PCP STANDARD**: 95% of members can access care within 2-4 days
- **NON-PCP STANDARD**: 95% of members can access care within 30 days

### URGENT MEDICAL PROBLEMS
- Unexpected illnesses or injuries requiring medical attention soon after they appear.
- **PCP STANDARD**: 95% of members can access care within 1-2 days
- **NON-PCP STANDARD**: 95% of members can access care within 1-2 days

### SERIOUS EMERGENCIES
- Life-threatening illness or injury, such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding or convulsions.
- **PCP STANDARD**: Immediate Care
- **NON-PCP STANDARD**: Immediate Care

## BEHAVIORAL HEALTH

### ROUTINE ASSESSMENTS OR CARE FOR NEW PROBLEMS
- Non-urgent, non-emergent conditions, initial post-hospitalization visit, new behavioral or mental health problems.
- **STANDARD**: 95% of members are offered access to care within 14 days

### ROUTINE FOLLOW-UP VISITS
- Continued or recurring problems when member, primary care physician and behavioral health care provider agree with or prefer the scheduled time.
- **STANDARD**: 95% of members are offered access to care within 30 days

### URGENT CARE
- Unexpected illnesses or behaviors requiring attention soon after they appear.
- **STANDARD**: 95% of members are offered access to care within 1-2 days

### IMMEDIATE CARE FOR NON LIFE-THREATENING EMERGENCY
- Severely limited ability to function; behavioral health care provider may either provide immediate care, or direct the patient to call 911 or be taken to nearest emergency room.
- **STANDARD**: Immediate Care, Not to Exceed 6 hours

### LIFE-THREATENING EMERGENCY (SELF OR OTHERS)
- The expectation is that the member will receive immediate care appropriate for the critical situation, e.g., calling 911.
- **STANDARD**: Immediate Care

## TELEPHONE ACCESS

### ACCESS TO CARE AFTER HOURS
- **ALL PROVIDERS**: 95% of members will find access to care after hours acceptable

### RETURN PHONE CALLS FROM PROVIDER OFFICE DURING OFFICE HOURS
- **ALL PROVIDERS**: 95% of members will find return phone calls during office hours to be acceptable
New Reimbursement Incentive for ADD/ADHD Medication Follow-up Phone Call for Commercial and Medicaid Members

Successful therapy is directly related to follow-up care. It has been shown that three (3) contacts with the patients by a practitioner increases compliance with the medication regimen. One follow-up face-to-face contact should be made between initiation and day thirty (30) of medication therapy and two contacts during days 31-300 of therapy, one of which may be a phone call follow-up consultation.

Paramount reimburses for one phone consultation from your office to the patient.

To meet the criteria for this additional reimbursement, the phone consultation should be made during the maintenance phase (days 31-300) of ADD/ADHD medication therapy. Such reimbursement is limited to once per calendar year per qualifying member. This call is intended to reinforce medication compliance and assess therapeutic effectiveness and is NOT a substitute for psychotherapy or other clinical services.

<table>
<thead>
<tr>
<th>CRITERIA AND CODING FOR PHONE CONSULTATION BILLING / ANTIDEPRESSANT THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Specialty Eligible for Reimbursement</strong></td>
</tr>
</tbody>
</table>
| **ICD 9 Codes Required for Payment** | Attention Deficit Disorder without mention of hyperactivity: 314.00  
Attention Deficit Disorder with hyperactivity: 314.01 |
| **Required CPT Code** | Use CPT Code:  
98966 non-physician; 99441 physician (5 - 10 minutes)  
98967 non-physician; 99442 physician (11 - 20 minutes)  
98968 non-physician; 99443 physician (21 - 30 minutes)  
(A telephone call from a non-physician health-care professional/physician to a patient for consultation and/or medical management; simple and brief.) |
| **Documentation** | Phone call should be documented in the patient’s chart with:  
Date of call  
Time of call  
Length of call  
Summary of discussion  
Or, use the Script on the following page. |
| **Reimbursement and Co-payment** | $40 reimbursement for CPT codes 98966; 98967; 98968; 99441; 99442; 99443  
NO CO-PAYMENT WILL BE APPLIED TO THE PHONE CALL |

If you have further questions, please contact your Provider Relations Representative at:  
(419) 887-2848 or (800) 891-2542.
ADD/ADHD Medication Follow-up Phone Call Script

Name ____________________________________ ID # ____________________ Date______________

I'm calling to talk with you about your child who is taking medication for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder:

1. Is your child still taking the medication?
   - Yes  Go to Question 3
   - No   Go to Question 2

2. Can you tell me why not? _______________________________________________________
   ___________________________________________________________________________

   If not yet filled, advise to fill script; repeat call in two weeks. No further questions.
   If filled but stopped taking, encourage making an appointment to discuss. No further questions.

3. Have you noticed any improvement in symptoms and/or behavior?
   - Yes  In what way(s)_____________________________________________________________
   ___________________________________________________________________________

   Reinforce need to continue to take medication, even if symptoms have improved, to reduce the chance of having the symptoms return.
   - No   Stress the need to continue the medication. May want to consider making an appointment to discuss dose adjustment or a different medication.

4. How is your child tolerating the medication? _______________________________________________
   List any side effects mentioned________________________________________________________

   Reinforce that many side effects disappear over time once the body adjusts to new medicines. If severe, schedule an appointment to discuss.

5. How is your child sleeping? (i.e., Falling asleep OK? Through the night? How many hours?)

6. How is your child's appetite? (How many meals a day? Weight gain/loss?)

7. Have you had any follow-up with your child’s school, teachers, grades, etc?
   - Yes  In what way? _______________________________________________________________
   ___________________________________________________________________________
   - No

8. Is there a follow-up visit scheduled?
   - Yes  (Date)___________________
   - No   Schedule an appointment.

9. Do you have any questions? ______________________________________________________________
   ___________________________________________________________________________

10. (May want to consider pharmacy consult if on multiple medications, e.g., asthma, diabetes or psychiatric referral if multiple ADD/ADHD meds have been tried without success.)
Clinical Practice Guidelines

The Clinical Guidelines for Physicians can be reviewed and printed by physicians and physician offices from the Paramount web site. These guidelines are evidenced-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. The guidelines will not cover every clinical situation and are not intended to replace clinical judgement.

The following guidelines have been reviewed and approved in 2012:

- Pediatric Preventive Care Guidelines based on American Academy of Pediatrics (AAP) Guidelines, 2010; with additional Recommendations from AAFP and ACOG. Adopted with changes August 2012.
- “Standards of Medical Care for Patients with Diabetes Mellitus,” American Diabetes Association (ADA), 2012 (Updated by ADA annually) Note: Includes pre-diabetes. Adopted February 2012.
- “Recommended Childhood Immunization Schedule,” Centers for Disease Control and Prevention (CDC), 2012 (Updated by CDC at least annually). Adopted March 2012.
- Prenatal and Postpartum Care Guidelines based on “Guidelines for Perinatal Care,” 6th Ed, American College of Obstetricians & Gynecology (ACOG) and AAP, Revised 2009. Readopted without changes August 2012.
- Clinical Guideline for Outpatient Management of Chronic Heart Failure based on “2009 Focused Update of American College of Cardiology/American Heart Association (ACCF/AHA) Guideline on Diagnosis and Management of CHF in Adults,” 2011. Readopted without changes, October 2012.
- Cholesterol Management Guideline based on the “National Cholesterol Education Program (NCEP)” Expert Adult Treatment Panel III, 2004 (Readopted May 2012; update due in 2012)

To view the guidelines go to www.paramountthehealthcare.com, click on “Provider,” then click on “Publications and Resources,” then “Clinical Practice Guidelines.”

2011 Quality of Care Report

Paramount’s 2011 Quality of Care Report was accepted by the Medical Advisory Council in June 2012. This summary represents one element of Paramount’s program to ensure that high-quality health care is delivered to all members, every time they seek it. Compared with prior years, very little has changed in the volume or characteristics of reports concerning possible quality-of-care issues. Infection following a healthcare procedure is still a prominent cause for reporting. Miscommunication between practitioner and patient (or parent) also remains a very common source of concern. A change from past years is increased recognition of hospitalists’ role in dissatisfaction with inpatient care. Opportunities for improvement continue to exist, as presented. The following plans to improve quality of care at Paramount and Paramount Advantage were suggested:

• Investigate automation for member self-reporting of perceived quality-of-care issues through a web site housed protocol. Careful design could also serve to educate about delivery of care expectations, dissipate member anger or anxiety and improve accuracy of complaint information. Tools of this sort have already been established and proven successful, such as those at ISMP, FDA MedWatch, The Joint Commission, Ohio’s Department of Health and most certified Patient Safety Organizations.
• Define tracking threshold and duration, and clarify the process for following up on corrective action plans (CAPs) to ensure compliance. Assure consistency among all policies and procedures.
• Update ProMedica Policy #CP 2.02.2 to ensure that every “Never Event” involving a Paramount and Paramount Advantage member is communicated to Paramount’s President, or designee such as the vice president and medical director (procedure 11).
**Medicare** Member Rights and Responsibilities

PURPOSE: To provide subscribers of Paramount’s Medicare product line with information regarding their individual rights and responsibilities pertaining to participation in their chosen Health Plan.

DEFINITION: Member Rights and Responsibilities are defined as those privileges and obligations extended to subscribers participating in Paramount Elite or Paramount PDP.

POLICY: It is the policy of Paramount Care, Inc., Paramount Care of Michigan, Inc., and Paramount Insurance Inc. to provide the plan specific Evidence of Coverage to all members annually and to newly enrolled members no later than when the member is notified of confirmation of enrollment or per CMS guidelines. The member’s EOC explains the member’s rights, benefits, and responsibilities as a member of Paramount Elite or Paramount PDP.

PROCEDURE:
1. Upon enrollment in the Health Plan, each new member will receive a copy of the Plan Evidence of Coverage for the member’s chosen product which contains written documentation of Member Rights and Responsibilities in accordance with the Center for Medicare and Medicaid Services (CMS) regulations.
2. Members will be strongly encouraged by enrollment representatives to review their documented “Rights and Responsibilities” carefully and to direct any questions to the Member Services Department.
3. The Evidence of Coverage document shall be updated annually to reflect mandatory changes in the “Member Rights and Responsibilities” section to ensure compliance with federal regulations and Center for Medicare and Medicaid Services (CMS) policy.
4. The Director of Federal Programs shall oversee the process and staff responsible for initiating any additions, deletions and/or modifications to this policy in compliance with Paramount Corporate Policy.
**Commercial Member Rights and Responsibilities - Ohio & Michigan**

**PURPOSE:** To provide subscribers of Paramount with information regarding their individual rights and responsibilities pertaining to participation in their chosen Health Plan.

**DEFINITION:** Member Rights and Responsibilities are defined as those privileges and obligations extended to subscribers participating in Paramount.

**POLICY:** It is the policy for Paramount to provide written documentation regarding Member Rights and Responsibilities as contained in the Member Handbook. The Member Rights and Responsibilities are as follows:

**Member Rights**

All Members have the right to:

1. Receive information about Paramount, its services, practitioners and providers, and their rights and responsibilities.
2. Participate with their physicians in decision making regarding their health care.
3. A candid discussion of appropriate or medically necessary treatment options for the conditions regardless of cost or benefit coverage.
4. Voice complaints or appeals about the health plan or care provided.
5. Make recommendations regarding the organization’s member rights and responsibilities policies.
6. Be treated with respect, recognition of their dignity and the need for privacy.

**Member Responsibilities**

All Members have the responsibility to:

1. Provide, to the extent possible, information that Paramount and participating practitioners and providers need in order to care for them.
2. Engage in a healthy lifestyle, become involved in their health care and follow the plans and instructions for the care that they have agreed on with their PCP or specialists.
3. Responsibility to understand their health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.

**Patient Rights and Responsibilities**

Michigan law sets forth the following rights and responsibilities for health care patients:

1. A patient or resident is responsible for following the health facility rules and regulations affecting patient or resident care and conduct.
2. A patient or resident is responsible for providing a complete and accurate medical history.
3. A patient or resident is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do.
4. A patient or resident is responsible for following the recommendations and advice prescribed in a course of treatment by the physician.
5. A patient or resident is responsible for providing information about unexpected complications that arise in an expected course of treatment.
6. A patient or resident is responsible for being considerate of the rights of other patients or residents and health facility personnel and property.
7. A patient or resident is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations.
Covered Families and Children Medicaid Consumers, including Healthy Start/Healthy Families Members’ Rights & Responsibilities

PURPOSE: To establish fair and communicate/disseminate, consistent rights and responsibilities of Covered Families and Children Medicaid consumers, including Healthy Start/Healthy Families members.

DEFINITION: Rights mean benefits and services that will be available to Covered Families and Children Medicaid consumers, including Healthy Start/Healthy Families members. Responsibilities mean acts or behaviors that are the duty of the Medicaid member.

POLICY: RIGHTS OF PERSONS ELIGIBLE FOR COVERED FAMILIES AND CHILDREN MEDICAID CONSUMERS, INCLUDING HEALTHY START/HEALTHY FAMILIES REGARDING HEALTH INSURING CORPORATIONS (HICs):

1. Persons eligible for Covered Families and Children Medicaid consumers, including Healthy Start/Healthy Families have the right to select a HIC qualified to serve Medicaid recipients in their county of residence.

2. Membership is mandatory in all eighteen counties in the NW Region. As of June 1, 2006, pending and new members will no longer have the right to request continuity of care deferments due to ODJFS specified prescheduled health services. Such members having prescheduled services with a non-contracted provider must contact PA in advance of the service date to coordinate services and agreed upon reimbursement. Additionally, an eligible individual may request exclusion from membership when as a result of a special health care condition and/or circumstances as determined by ODJFS. Membership will not affect eligibility for Covered Families and Children Medicaid consumers, including Healthy Start/Healthy Families-related benefits. A HIC cannot refuse members based upon their race, creed, color, religion, sex, sexual orientation, age, disability, national origin, Vietnam-era veteran’s status or other veteran status, place of residence, source of payment or credit history, ancestry, health status or need for health services.

3. A member in a HIC has the right to contact the Ohio Department of Job and Family Services (ODJFS) managed Care Enrollment Center (1-800-605-3040, TTY1-800-292-3572), to transfer to another HIC, request a just cause disenrollment or to return to fee-for-service Medicaid if they meet ODJFS’ requirements for Optional MCP Enrollment. Persons must choose another HIC at the time of termination. Terminations will be effective no later than the first day of the second month following the date upon which a termination form is completed.

4. Terminations may only be processed during the first three months of membership, or during the annual open selection month for the NW Region or with “just cause” reason as determined by the ODJFS. It is the member’s responsibility to contact the Bureau of Managed Health Care ODJFS at 50 West Town Street, Suite 400, Columbus, OH 43215, 614-466-4693 or the Managed Care Enrollment Center, if an application for “just cause” reason to terminate is desired. “Just cause” reason shall be granted, in writing, only by ODJFS.

5. No members will be forced to terminate by the HIC because of their health status or need for health services.

6. Members in a HIC have the right to receive, at a minimum, the same services they would receive under Medicaid, provided that they receive all medical services, except emergency services, in or through HIC facilities or providers.

7. Members in a HIC have the right to receive preventive health care education services under the direction of a provider including, for persons under age twenty-one (21), HEALTHCHEK services.
Covered Families and Children Medicaid Consumers continued

8. Members in an HIC have the right to file a grievance or appeal and receive an answer regarding the policies, personnel or practices of a HIC. HIC members also have the right to submit grievances or decisions with which they disagree, to the Director of the Ohio Department of Insurance and the Ohio Department of Job and Family Services.

9. Members in a HIC have the right to quality services, appropriate to their health care needs, which are delivered in a timely manner.

MEMBERS HAVE THE RIGHT TO:
- to receive all services that Paramount Advantage must provide.
- be treated with respect and with regard, for their dignity and privacy.
- be sure that their medical record information will be kept private.
- be given information about their health. Such information may also be available to someone who they have legally authorized to have the information or whom they said should be reached in an emergency when it is not in the best interest of their health to give it to them.
- be able to take part in decisions about their health care unless it is not in their best interest.
- get information on any medical care treatment, given in a way that they can follow.
- be sure that others cannot hear or see them when they are getting medical care.
- be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- ask, and get, a copy of their medical records, and to be able to ask that their record be changed/corrected if needed.
- be able to say yes or no to having any information about them given out unless Paramount Advantage has to by law.
- be able to say no to treatment or therapy. If they say no, the doctor or Paramount Advantage must talk to them about what could happen, and they must put a note in their medical record about it.
- be able to file an appeal, a grievance (complaint) or state hearing about Paramount Advantage, the doctors or the care they received.
- be able to get all written member information from Paramount Advantage:
  - at no cost to the member;
  - in the prevalent non-English languages of members in the Paramount Advantage service area;
  - in other ways, to help with the special needs of members who may have trouble reading the information for any reason;
  - be able to get help free of charge from Paramount Advantage and its providers if they do not speak English or need help in understanding information.
- be able to get help with sign language if they are hearing-impaired.
- be told if the health care provider is a student and to be able to refuse his/her care.
- be told of any experimental care and to be able to refuse to be part of the care.
- make advance directives (a living will).
- file any complaint about not following their advance directives with the Ohio Department of Health.
- change their Primary Care Provider (PCP) to another PCP on Paramount Advantage’s panel at least monthly. Paramount Advantage must send them something in writing that says who the new PCP is and the date the change began.
- be free to carry out their rights and know that Paramount Advantage and its participating providers or ODJFS will not hold this against them.
- know that the Paramount Advantage must follow all federal and state laws, and other laws about privacy that apply.
MEMBERS HAVE THE RESPONSIBILITY TO:

- provide, to the extent possible; information that Paramount Advantage and the participating providers need to care for them. Help their PCP fill out current medical records by providing current prescriptions and their previous medical records.
- engage in a healthy lifestyle, become involved in their health care and follow the plans and instructions for the care that they have agreed upon with their PCP or specialists.
- treat their Primary Care Provider (PCP) with respect and dignity.
- inform their PCP of any symptoms and problems and to ask questions.
- obtain information and consider the information about any treatment or procedure before it is done. Discuss any problems in following the recommended treatment with your PCP.
- respect the privacy of other patients in the office.
- obtain pre-authorization from their PCP, or the doctor or facility taking their calls, before seeing a consultant/specialist. The only times they do not need to contact their PCP to see a consultant/specialist are for appointments with obstetricians, gynecologists, certified nurse practitioners, certified nurse-midwives, qualified family planning providers, ODADAS and community mental health Medicaid providers, federally qualified health center providers and vision and dental providers (routine care only).
- continue seeing their previous PCP until the transfer takes effect.
- continue following Paramount Advantage policies and procedures until disenrollment takes effect.
- schedule and keep appointments and be on time. Always call if they need to cancel an appointment or if they will be late.
- learn and follow policies and procedures as outlined in the handbook.
- indicate to their doctor who they wish to designate to receive information regarding their health.
- obtain medical services from their PCP.
- treat their PCP and his or her staff in a polite and courteous manner.
- become involved in their health care and cooperate with your PCP regarding recommended treatment.
- carry their ID card at all times and report any lost or stolen cards to Paramount Advantage immediately. Also, contact Paramount Advantage if any information on the card is incorrect, or if there are changes in name, address or eligibility.
- inform Paramount Advantage of any dependent that is to be added or removed from coverage.
- notify their PCP as soon as possible if they have received emergency treatment with forty-eight (48) hours.
- call the Member Service Department if they have a problem and need assistance.
- choose the provider that gives you care whenever possible and appropriate.
- If they are female, be able to go to a woman’s health provider on Paramount Advantage’s panel for covered women’s health services.
- be able to get a second opinion from a qualified provider on the Paramount Advantage panel. If a qualified provider is not able to see them Paramount Advantage must set up a visit with a provider not on the panel.
- get information about Paramount Advantage from Paramount Health Care.
- to contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran’s status, ancestry, health status, or need for health services.
In addition to the rights listed above, Paramount Advantage members also have the right to:

- receive information about Paramount Advantage, its services, providers, and members’ rights and responsibilities.
- be treated with respect and recognition of their dignity and need for privacy.
- participate with providers in decision-making regarding their health care.
- a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- voice complaints or appeals about the managed care organizations or the care provided.
- receive equal and fair treatment (the quality of treatment that other patients receive).
- continue as a member of Paramount Advantage regardless of their health status or need for care.
- receive their ID cards and Member Handbooks in a timely manner.
- add new eligible dependents to their coverage.
- seek treatment for an Emergency Medical Condition without contacting their PCP. [“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses 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 or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of an bodily organ or part.]
- call the Member Service Department 24 hours a day at 419-887-2525 or toll free at 1-800-462-3589.
- a right to make recommendations regarding Paramount Advantage’s member rights and responsibilities policies.
**OHIO STATE LAW**

**BLOOD LEAD TESTING**

**AGES 1 AND 2 YEARS**

How do you determine if a child is at risk for lead poisoning?

There are three ways to determine if a child is at risk. Ohio State Law Substitute House Bill 248 requires that:

1) All Medicaid & Healthy Families and all Healthy Start Consumers (regardless of ZIP code or exposure to lead) receive a blood lead test at age 1 and again at age 2.

2) All children residing in a high-risk ZIP code area receive a blood lead test at age 1 and again at age 2.

3) A Risk Assessment Questionnaire must be used for all other children (low-risk ZIP codes) in this age category. For a list of risk assessment questions, follow the directions below. A blood lead test must be completed if the answer is yes or unknown to any of the questions.

Additionally, every Medicaid-eligible child between the ages of 36 and 72 months must have a blood lead screening test unless you have documentation that the child has been previously screened for lead poisoning.

For a list of high-risk ZIP codes and the Risk Assessment Questionnaire, please go to www.odh.ohio.gov. Scroll down to “Resources,” then select “ODH Programs.” Select the down arrow under “Programs.” Scroll down and select “Lead Poisoning - Children,” then Submit. Select “High-risk Codes” in the left-hand column. When finished, click on the back arrow. The Ohio Childhood Lead Poisoning Prevention Screening Recommendations (including the Risk Assessment Questionnaire) can be located by selecting the highlighted title in the 3rd paragraph. Additional web sites are jfs.ohio.gov/ohp/bhpp/lpplpt/providerlead.stm or the Environmental Protection Agency (EPA) web site at www.epa.gov/lead.

For a local assistance on lead poisoning and housing inspection/abatement, please contact the Toledo Lucas County Health Department at 419-213-4109, the City of Toledo at 419-245-1400 (and ask for the Lead Based Paint Program), or the Ohio Department of Health for Childhood Lead Poisoning Prevention at 1-877-LEAD-SAFE.

Helpful tips to increase blood lead screening rates:

- Implement well-child check lists that include blood lead testing.
- Implement office-based tickler (recall) system to assure blood levels are obtained and results filed in medical records.
- Inform parents, providers, and community of the need for blood lead testing.
- Develop a one-step approach to blood lead testing; do the blood draws in your office.
HEALTHCHEK is a federal and state (well-visit) mandate for Medicaid members from birth through the age of 20 years.

HEALTHCHEK Screening Service Frequencies
ODJFS will follow the frequency recommendations for preventive pediatric health care developed by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics (AAP). The AAP frequencies are as follows:

- Eight screens from new born through 12 months;
- Exams at 15 months, 18 months, 24 months, 30 months and;
- One screen per year from ages 3 through age 20.

Minimal Requirements of a Complete HEALTHCHEK Exam:
- Comprehensive Health and Developmental History
- Comprehensive Unclothed Physical Exam
- Health Education/Counseling, and Anticipatory Guidance
- Developmental Assessment (Physical and Mental Health Development)
- Nutritional Assessment
- Vision Assessment
- Hearing Assessment
- Immunization Assessment
- Lead Assessment (Blood lead test between age 1 and age 2, and when medically indicated)
- Laboratory Tests (when medically indicated)
- Dental Assessment

Physician Role:
- Perform and document complete HEALTHCHECK exams during sick and well visits
- Bill according to guideline
- Educate members on importance of well visits, immunizations, dental visits and blood lead testing

ODJFS and Paramount monitor compliance with the HEALTHCHEK standards on an annual basis via administrative claims data and random medical record documentation auditing for the HEDIS® study.

For additional billing information and age-specific Well Child Exam forms, please go to www.paramounthealthcare.com. Click “Providers,” then “Publications and Resources,” then “Healthchek.” There you will find the Healthchek Coding Guide, Healthchek Provider Powerpoint, Healthchek Webinar brochure, and Paramount Advantage Healthchek Program Guidelines.

In the center of the screen are 17 age-specific Well Child Exam forms. These forms were developed by the collaborative of Ohio Managed Care Plans with ODJFS and meet the requirements for all Medicaid plans across the state. They may be printed and copied at no charge. If you currently have your own Well Visit form, please compare it to the age-specific forms to make sure all the components of a complete Healthchek exam are included. These forms are not mandatory but are highly recommended to assure all the elements required by ODJFS are met during a Healthchek exam.

Coding correctly is very important to capture a Healthchek exam. For a list of billing codes, please refer to the Healthchek Coding Guide on the website.
Attention all Paramount Elite Member Providers:

You may be asked to complete a prescription verification form, relating to an investigation of potential prescription drug abuse fraud. This communication would come from Health Integrity, the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) for the Centers for Medicare & Medicaid Services (CMS). This form will detail the beneficiary’s name, the medication in question, date and quantity prescribed. You will be asked to indicate if you wrote the prescription and will have two weeks to respond to this request before another is issued.

It is reported that only 5 - 10% of all prescribers respond to prescription verification requests. Paramount asks that if you receive a prescription verification request that you complete it and return it in the appropriate time frame. Cooperation with the NBI MEDIC investigations will allow proper identification in cases of wrongdoing and possible prevention of payment for fraudulent prescriptions for Medicare Part D.