2012 Quality of Care Report

Paramount’s 2012 Quality of Care Report was accepted by the Medical Advisory Council in August 2013. 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. By investigating reported concerns with quality or access to care, requesting corrective action as appropriate, and tracking events where an issue did or had the potential to occur, Paramount maintains consistently high quality. Demands for regulatory compliance require increased attention to QOC investigation and several associated elements of care management. Among these are Serious Reportable Adverse Events among our members during inpatient care, and identification of Hospital-Acquired Conditions from hospital claims.

Conclusions: Compared with prior years, there was an increase in the volume of reports concerning possible quality of care issues, particularly in dental and emergency care complaints by Advantage members. More than half of all these reports were found to involve no potential for patient harm. Misunderstanding between practitioner and patient (or parent) about diagnosis and/or treatment plans remains a very common source of concern and dissatisfaction.

Recommendations:
1) Reconsider recommendations for improvement presented in previous annual reports
2) Ensure oversight of quality of care concerns among newly contracted providers and delegated entities
3) Encourage practitioners to take confusion or complaints from patients or families seriously since they may suggest a perceived breach in health care quality

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Preferred Brand Drug List Changes for 2014

The Pharmacy and Therapeutics Working Group, a subgroup of the Medical Advisory Council at Paramount, has reviewed and approved changes to the Preferred Brand Drug List for Commercial benefits. This Preferred Brand 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 multi-source brand and may no longer be covered or may be available at higher copayment levels.

2014 PDL Additions:
Delzicol® - Gastrointestinal Drugs
Dulera® - Respiratory
Eliquis® - Hematological
Janumet XR® - Diabetes
Jentadueto® - Diabetes
Prezista® Suspension - Antiretroviral
Tradjenta® - Diabetes

2014 PDL Deletions:
Advair® - Respiratory
Kombiglyze® - Diabetes
Onglyza® - Diabetes

2014 PDL Deletions with Generic Alternatives:
Aricept® - Autonomic & CNS
Bactroban® - Dermatological*
Climara® - OB/Gyn
Concerta® - Autonomic & CNS
Didronel® - Endocrine & Metabolic
Diovan® HCT - Antihypertensive
Dovonex® Cream & Solution - Dermatological
Duetact® - Diabetes
Estrostep FE® - Endocrine & Metabolic
Felbatol® - Neuromuscular
FS Shampoo® - Dermatological
Furadantin® Suspension - Antiinfective
Lovenox® - Hematological
Methergine® - Endocrine & Metabolic
Methylphenidate® ER - Autonomic & CNS
Migranal® - Migraine
Niaspan® - Cholesterol Lowering
Prandin® - Diabetes
Prometrium® - OB/Gyn
Starlix® - Diabetes
Tricor® - Cholesterol Lowering
Vancocin® - Antiinfective
Viramune XR® - Antiretroviral
Zomig® - Migraine

*Bactroban Nasal formulation remains on the Preferred Brand Drug List

Questions? Need a Full Preferred Brand Drug List?
If you have any questions about the prescription drug benefit or would like a copy of the complete 2014 Preferred Brand Drug List, call Provider Inquiry at 419-887-2564 or 888-891-2564. You can also visit Paramount’s web site at www.paramounthealthcare.com to access an online version.

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 a pharmacy to process an approved OTC medication under a member’s 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 you with better care and service. They also enable us to judge how we compare with health plans across the nation. Again this year, the Paramount results were strong. When compared with the national all-product average, Paramount scored higher in all eight comparable measures of member satisfaction.

This chart shows how Paramount compares with the 2012 national all-product averages in member satisfaction for Quality Compass®. Accredited health plans significantly outperform nonaccredited 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.

<table>
<thead>
<tr>
<th>Care and Services</th>
<th>Paramount Commercial</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>89.76% #</td>
<td>87.86%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>88.98% #</td>
<td>86.33%</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>95.09%</td>
<td>94.71%</td>
</tr>
<tr>
<td>Health Plan’s Customer Service ◊</td>
<td>N/A</td>
<td>87.17%</td>
</tr>
<tr>
<td>Rating of Health Care</td>
<td>80.89%</td>
<td>76.21%</td>
</tr>
<tr>
<td>Rating of Health Plan</td>
<td>68.81%</td>
<td>61.72%</td>
</tr>
<tr>
<td>Rating of Personal Doctor (PCP)</td>
<td>86.34%</td>
<td>83.71%</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>88.02%</td>
<td>83.15%</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td>73.28%</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
** HEDIS® and Quality Compass® are registered trademarks of the NCQA.
#Denotes statistically significant improvement from previous year (p≤0.05).
◊Response depends on member initiating contact with plan’s Member Service Department.
Quality Results: HEDIS® 2013 Highlights

The Paramount Healthcare Effectiveness Data and Information Set (HEDIS®) 2013 results are now available. The HEDIS® data for this reporting year were submitted to NCQA for publication in Quality Compass®, a national database with both clinical and nonclinical performance information from more than 360 Commercial (private) health plans. That allows purchasers to obtain regional and national comparisons of health plan performance. The HEDIS® data submitted by Paramount were independently audited to ensure compliance with stringent methodological standards, with 100 percent of the elements validated.

Improvements appear to be a direct result of specific, targeted interventions, such as:

- A member reminder system for immunizations
- Personalized letters and telephone outreach to members with specific testing and treatment recommendations
- Educational programs for members with certain conditions
- Physician and office staff education programs
- Direct contact with members and their physicians by Paramount Nurse Case Managers for those with chronic illnesses or catastrophic conditions
- Implementation of asthma, depression, diabetes, cardiac post-event, congestive heart failure, end-stage renal disease/chronic kidney disease, migraine, and osteoporosis management programs
- Health education and coaching calls to our members with asthma, diabetes, chronic obstructive pulmonary disease, migraines, and after-cardiac events

HEDIS® findings also demonstrate that health plans with a track record of public disclosure outperform others and demonstrate steady improvement across almost all measures. This year, Paramount ranked in the top 10 percent of Commercial health plans nationally for four HEDIS® measures:

- Alcohol and Drug Dependency: Initiation of Treatment
- Alcohol and Drug Dependency: Engagement in Treatment
- Chronic Obstructive Pulmonary Disease: Treatment with Systemic Corticosteroid
- Rheumatoid Arthritis: Disease-Modifying Therapy

Paramount ranked in the top 25 percent of Commercial health plans nationally on three more HEDIS® measures:

- Cervical Cancer Screening
- Postpartum Care
- Prenatal Care (Timeliness)

HEDIS® results can be seen on page 5.

* 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 underutilization and/or denials of coverage or care. In fact, Paramount monitors and analyzes monthly reports for patterns of underutilization 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 2012 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>80.05% †</td>
<td>Not applicable</td>
<td>70.56% †</td>
<td>83%/NA/72%</td>
</tr>
<tr>
<td>Adolescent Immunizations</td>
<td>64.34% †</td>
<td>Not applicable</td>
<td>56.20% †</td>
<td>34%/NA/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>69.36%</td>
<td>69.89%</td>
<td>43.72%</td>
<td>72%/74%/54%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (women ages 21-64)</td>
<td>80.43%</td>
<td>Not applicable</td>
<td>76.39%</td>
<td>82%/NA/87%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (men &amp; women ages 50-80)</td>
<td>61.56%</td>
<td>67.64%</td>
<td>Not applicable</td>
<td>62%/65%/NA</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>96.74% †</td>
<td>Not applicable</td>
<td>92.70% †</td>
<td>98%/NA/94%</td>
</tr>
<tr>
<td>Postpartum Care (at 21-56 days)</td>
<td>90.22% †</td>
<td>Not applicable</td>
<td>74.45% †</td>
<td>89%/NA/78%</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>68.93%</td>
<td>71.32% †</td>
<td>62.26%</td>
<td>68%/70%/66%</td>
</tr>
<tr>
<td>Persistent Beta Blocker Treatment After a Heart Attack</td>
<td>83.78%</td>
<td>91.49% †</td>
<td>Not reportable</td>
<td></td>
</tr>
<tr>
<td>Cholesterol Testing (annual)</td>
<td>87.83% †</td>
<td>88.56% †</td>
<td>74.32%</td>
<td>88%/94%/78%</td>
</tr>
<tr>
<td>Cholesterol Control (&lt;100 mg/dL)</td>
<td>65.94% †</td>
<td>69.34%</td>
<td>48.65% †</td>
<td>60%/66%/44%</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>87.83%</td>
<td>93.92%</td>
<td>84.43% †</td>
<td>93%/94%/84%</td>
</tr>
<tr>
<td>HbA1c Poorly Controlled (&gt;9.0%) (lower rate is better)</td>
<td>24.82%</td>
<td>13.63%</td>
<td>36.50%</td>
<td>≤21%/≤10%/≤35%</td>
</tr>
<tr>
<td>HbA1c Controlled (&lt;8%)</td>
<td>62.53% †</td>
<td>77.33%</td>
<td>53.77%</td>
<td>68%/80%/55%</td>
</tr>
<tr>
<td>Dilated Eye Exam (annual)</td>
<td>64.23%</td>
<td>77.13%</td>
<td>67.40% †</td>
<td>66%/82%/68%</td>
</tr>
<tr>
<td>Lipid Test (annual)</td>
<td>83.94%</td>
<td>89.29% †</td>
<td>72.51% †</td>
<td>88%/93%/73%</td>
</tr>
<tr>
<td>Lipid Control (&lt;100 mg/dL)</td>
<td>53.04%</td>
<td>65.45%</td>
<td>34.06% †</td>
<td>48%/59%/35%</td>
</tr>
<tr>
<td>Nephropathy Screening/Treatment (annual)</td>
<td>81.02% †</td>
<td>92.70% †</td>
<td>69.34%</td>
<td>84%/94%/77%</td>
</tr>
<tr>
<td>Blood Pressure Control (&lt;140/90)</td>
<td>74.94% †</td>
<td>72.02%</td>
<td>72.26% †</td>
<td>74%/69%/75%</td>
</tr>
<tr>
<td>Good Blood Pressure Control (&lt;140/80)</td>
<td>46.72% †</td>
<td>58.64%</td>
<td>44.77% †</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>44.68% †</td>
<td>Not applicable</td>
<td>45.97%</td>
<td>57%/38%/58%</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness - Within 30 days</td>
<td>73.62%</td>
<td>Not applicable</td>
<td>73.13%</td>
<td></td>
</tr>
<tr>
<td>Antidepressant Management - Acute Phase Medication Trial</td>
<td>56.31%</td>
<td>71.20% †</td>
<td>47.89%</td>
<td>70%/68%/52%</td>
</tr>
<tr>
<td>Antidepressant Management - Effective Continued Drug Therapy</td>
<td>41.59%</td>
<td>60.87% †</td>
<td>31.56% †</td>
<td>51%/56%/38%</td>
</tr>
<tr>
<td>ADHD - Initiation of Follow-Up Care</td>
<td>34.16%</td>
<td>Not applicable</td>
<td>49.25% †</td>
<td>39%/NA/42%</td>
</tr>
<tr>
<td>ADHD - Maintenance of Follow-Up Care</td>
<td>52.78% †</td>
<td>Not applicable</td>
<td>56.84%</td>
<td>39%/NA/42%</td>
</tr>
<tr>
<td>Initiation of Treatment for Alcohol &amp; Other Substance Dependence</td>
<td>46.80%</td>
<td>47.62%</td>
<td>44.78%</td>
<td>52%/43%/40%</td>
</tr>
<tr>
<td>Engagement of Treatment for Alcohol &amp; Other Substance Dependence</td>
<td>18.31%</td>
<td>3.17%</td>
<td>19.29%</td>
<td>21%/2%/14</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>92.33%</td>
<td>Not applicable</td>
<td>87.48%</td>
<td>94%/NA/93%</td>
</tr>
<tr>
<td>Spirometry Testing for COPD</td>
<td>41.95%</td>
<td>31.77%</td>
<td>31.67%</td>
<td>76%/66%</td>
</tr>
<tr>
<td>Use of Systemic Corticosteroid for COPD</td>
<td>88.89%</td>
<td>82.20% †</td>
<td>77.29%</td>
<td></td>
</tr>
<tr>
<td>Use of Bronchodilator for COPD</td>
<td>86.11%</td>
<td>62.83% †</td>
<td>79.55%</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>82.26% †</td>
<td>Not applicable</td>
<td>76.31%</td>
<td>88%/NA/83%</td>
</tr>
<tr>
<td>Adults with Bronchitis</td>
<td>18.97%</td>
<td>Not applicable</td>
<td>18.75% †</td>
<td>25%/NA/24%</td>
</tr>
<tr>
<td>Strept Testing for Children with Pharyngitis</td>
<td>67.82%</td>
<td>Not applicable</td>
<td>58.31% †</td>
<td>76%/NA/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>60.34% †</td>
<td>NA/NA/59%</td>
</tr>
<tr>
<td>HPV Immunization for Adolescent Females</td>
<td>10.22%</td>
<td>Not applicable</td>
<td>15.57%</td>
<td>/NA</td>
</tr>
<tr>
<td>Chlamydia Screening in Women (ages 16-24)</td>
<td>33.01% †</td>
<td>Not applicable</td>
<td>50.58%</td>
<td>40%/NA/</td>
</tr>
<tr>
<td>Adult Flu Shots (survey question)</td>
<td>52.63%</td>
<td>76.09% †</td>
<td>Not applicable</td>
<td>57%/78%/na</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>83.68%</td>
<td>83.58% †</td>
<td>71.36% †</td>
<td>/ /</td>
</tr>
<tr>
<td>Weight in Kids - BMI</td>
<td>57.91% †</td>
<td>Not applicable</td>
<td>54.50% †</td>
<td>/NA</td>
</tr>
<tr>
<td>Weight in Kids - Nutrition Counseling</td>
<td>69.83%</td>
<td>Not applicable</td>
<td>54.74% †</td>
<td>/NA</td>
</tr>
<tr>
<td>Weight in Kids - Activity Counseling</td>
<td>63.59% †</td>
<td>Not applicable</td>
<td>44.77% †</td>
<td>/NA</td>
</tr>
<tr>
<td>Advising Smokers to Quit (survey question/2-year average)</td>
<td>Not reportable</td>
<td>90.32%</td>
<td>69.91% †</td>
<td>78%/70%/68%</td>
</tr>
<tr>
<td>Imaging Studies for Back Pain</td>
<td>68.41%</td>
<td>Not applicable</td>
<td>70.61%</td>
<td>78%/NA/78%</td>
</tr>
<tr>
<td>Osteoporosis Management</td>
<td>Not applicable</td>
<td>15.30%</td>
<td>Not applicable</td>
<td>NA/29/NA</td>
</tr>
<tr>
<td>Glaucome Screening</td>
<td>Not applicable</td>
<td>73.23%</td>
<td>Not applicable</td>
<td>NA/78%/NA</td>
</tr>
</tbody>
</table>
Antibiotic resistance has been called one of the world’s most pressing public health problems.

- The number of bacteria resistant to antibiotics has increased in the last decade.
- Many bacterial infections are becoming resistant to the most commonly prescribed antibiotic treatments.
- Every time a person takes antibiotics, sensitive bacteria are killed, but resistant germs may be left to grow and multiply.
- Repeated and improper uses of antibiotics are primary causes of the increase in drug-resistant bacteria.
- Misuse of antibiotics jeopardizes the usefulness of essential drugs.
- Decreasing inappropriate antibiotic use is the best way to control resistance.
- Children are of particular concern because they have the highest rates of antibiotic use.

### For more information:
## Access Standards

### Medical / Surgical

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PCP Standard</th>
<th>Non-PCP Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Assessments, Physicals or New Visits</strong></td>
<td>95% of members can access care within 30 days</td>
<td>95% of members can access care within 60 days</td>
</tr>
<tr>
<td><strong>Routine Follow-up Visits</strong></td>
<td>95% of members can access care within 14 days</td>
<td>95% of members can access care within 45 days</td>
</tr>
<tr>
<td><strong>Symptomatic Non-urgent Visits</strong></td>
<td>95% of members can access care within 1 working day after PCP contact</td>
<td>95% of members can access care within 30 days</td>
</tr>
<tr>
<td><strong>Urgent Medical Problems</strong></td>
<td>95% of members can access care within 1-2 days</td>
<td>95% of members can access care within 1-2 days</td>
</tr>
<tr>
<td><strong>Serious Emergencies</strong></td>
<td>Immediate Care</td>
<td>Immediate Care</td>
</tr>
</tbody>
</table>

### Behavioral Health

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Assessments or Care for New Problems</strong></td>
<td>95% of members are offered access to care within 14 days</td>
</tr>
<tr>
<td><strong>Routine Follow-up Visits</strong></td>
<td>95% of members are offered access to care within 30 days</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>95% of members are offered access to care within 1-2 days</td>
</tr>
<tr>
<td><strong>Immediate Care for Non-Life Threatening Emergency</strong></td>
<td>Immediate Care, Not to Exceed 6 hours</td>
</tr>
<tr>
<td><strong>Life Threatening Emergency (Self or Others)</strong></td>
<td>Immediate Care</td>
</tr>
</tbody>
</table>

### Dental (Paramount Advantage only)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Care</strong></td>
<td>95% of members can access care within 60-90 days</td>
</tr>
<tr>
<td><strong>Routine Follow-up</strong></td>
<td>95% of members can access care within 14-45 days</td>
</tr>
<tr>
<td><strong>Symptomatic / Non-Urgent</strong></td>
<td>95% of members can access care within 7-14 days</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>95% of members can access care within 72 hours</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>95% of members can access care within 24 hours</td>
</tr>
</tbody>
</table>

### Telephone Access

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Care After Hours</strong></td>
<td>95% of members will find access to care after hours acceptable</td>
</tr>
<tr>
<td><strong>Return Phone Calls from Provider Office During Office Hours</strong></td>
<td>95% of members will find return phone calls during office hours to be acceptable</td>
</tr>
</tbody>
</table>
The health care industry is preparing for monumental changes as it transitions toward implementing the International Classification of Diseases, Tenth Revision, also known as ICD-10.

**ICD-10 is a new code set for reporting medical diagnoses (ICD-10-CM) & inpatient procedures (ICD-10-PCS).**

**Upgrading to ICD-10 will:**
- Provide better data for measuring health care service quality, safety and efficacy of care
- Allow clinical IT systems to record far more specific and rich diagnostic information
- Boost efficiencies by helping to identify specific health conditions

**Will ICD-10-PCS replace CPT?**
No. ICD-10-PCS will be used to report hospital inpatient procedures only. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) will continue to be used to report services and procedures in outpatient and professional settings. However, all claims (inpatient, outpatient, and professional) will require an ICD-10 diagnosis.

**Who is required to prepare for this change?**
The coding system conversion will affect the entire health care continuum. All providers covered under HIPAA are required to be compliant.

**When is the required date for implementation?**
All providers and payers under HIPAA are required to be compliant with ICD-10 on 10/1/14. Claims with discharge dates or dates of service prior to the compliance cutoff of 10/1/14, should continue to be coded with ICD-9 codes.

Inpatient claims with discharge dates on or after 10/1/14 must be coded in ICD-10. Interim bills for long hospital stays are expected to follow the same rules as other claims. If an inpatient provider submits a replacement claim to cover all interim stays, the provider must re-code all diagnoses/procedures to ICD-10 since the replacement claim will have the discharge date post compliance.

Outpatient and professional claims with dates of service on or after 10/1/14 must contain ICD-10 diagnosis codes. Claims may not contain a combination of ICD-9 and ICD-10 codes. Individual claims may only contain one code set. Outpatient and professional claims with from/through service dates that span the compliance date should be split into two claims (One claim for dates of service prior to 10/1/14, with ICD-9 codes and one claim for dates of service on or after 10/1/14, with ICD-10 codes).

**What should providers do to prepare?**
Providers can begin preparing by taking the following steps:
- Talk with your billing service, clearinghouse, or practice management software vendor about their ICD-10 readiness plans and ensure software updates will be installed.
- Identify ICD-9 and ICD-10 touch points in your system and business processes.
- Identify needs and resources, such as staff training.
- Determine if billing forms need to be updated for compliance.
- Conduct external testing with your clearinghouses and payers to make sure you can send and receive transactions with the ICD-10 codes.

If you handle billing and software development internally, you should develop a plan for your medical records/coding, clinical, IT and finance staff to coordinate ICD-10 transition efforts.
> What do the Ohio Department of Medicaid (ODM) and Managed Care Plans (Plans) recommend for network providers about the transition?
Physicians and facility partners who have not yet begun planning for the transition to ICD-10 need to begin immediately. Those who have already begun ICD-10 transition plans should continue on course to ensure a successful transition. Implementation planning is critical to the success of ICD-10, including testing the new system and communicating with health plan partners prior to 10/1/14. Being prepared can significantly improve how your organization fares during this transition by minimizing the financial and productivity impacts in the first years after implementation. Preparation also avoids any potential issues with the CMS partial code freeze that is in place until October 1, 2015.

> Will ODM and the Plans meet the 10/1/14 compliance date and be capable of accepting transactions containing ICD-10 codes?
Effective 10/1/14, ODM and all the Plans will be able to accept transactions containing ICD-10-CM and ICD-10-PCS codes as well as ICD-10 based DRGs.

> How are ODM and the Plans working together?
While each Plan, like all HIPAA covered entities, is required to implement ICD-10, ODM and the Plans are working collaboratively to ensure the smoothest transition possible for Ohio Medicaid. ODM and the Plans have frequent communications to coordinate efforts and ensure readiness.

> Is there a transition period? After 10/1/14, will ODM and the Plans no longer accept ICD-9 codes?
There is not a transition period. However, the implementation deadline is based on date of service or discharge and not the date of claim submission. Because of timely filing rules, ICD-9 codes will continue to be accepted after 10/1/14 but ONLY for claims with dates of service or discharge prior to 10/1/14. Timely filing rules do not change the regulation that all claims with dates of service or discharge on or after 10/1/14 must contain ICD-10 codes.

> Will reimbursement change with ICD-10?
At this time, we do not anticipate significant changes to provider reimbursement for providers that are compliant with the implementation deadline.

> What if providers are not ready by the compliance deadline?
Any ICD-9 codes used in claims with dates of service or discharge on or after 10/1/14, will be rejected as non-compliant and the claims will not be processed. You will have disruptions in your claims being processed and receipt of your payments.

> Do(es) ODM or the Plans expect delays in payment during the transition?
Although ODM and the Plans strive for minimal disruption in operations, we acknowledge that with any implementation there is potential for an increase in processing time and inquiries for a short term period during the change. ODM and the Plans will leverage proven techniques to effectively manage increased volume in any area requiring it.

> What will the appeal process be for resubmission of ICD-9 based claims after 10/1/14?
ODM and the Plans will follow the date of service of the claims; if it was originally filed with ICD-9 coding and the date of service was prior to 10/1/14, we will continue to accept that claim through the appeal process with ICD-9 coding.

ICD-10 ONLINE
Check the ODM website for ICD-10 updates & find links to Medicaid Managed Care Plan ICD-10 updates.

OHIO DEPARTMENT OF MEDICAID:

CENTERS FOR MEDICARE & MEDICAID SERVICES:
www.cms.gov/ICD10
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 2013:

- **Adult and Senior Preventive Care Guidelines** are based on “Guide to Clinical Preventive Services,” U.S. Preventive Services Task Force (USPSTF) 2009 and are based on USPSTF @ AHRQ Home/Clinical Information/U.S. Preventive Services Task Force recommendations. For adults, the pap test was changed to reflect ACOG 2013 and the USPSTF 2012 guidelines changed the age, frequency and added HPV testing. For senior adults, the pap test was changed to reflect ACOG 2013 and the USPSTF 2012 guidelines to discontinue testing for women older than age 65 who have had adequate prior screening and are not high risk. The guidelines were adopted with changes August 2013.

- **Pediatric Preventive Care Guidelines** are based on American Academy of Pediatrics (AAP) Guidelines, 2008, with additional recommendation from the AAP to begin cholesterol screening at age 10. The guidelines were adopted with changes August 2013.

- **Adult and Pediatric Asthma**. “Guidelines for Diagnosis and Management of Asthma,” National Asthma Education and Prevention Expert Panel Report III (EPR-3), National Heart, Lung and Blood Institute (NHLBI), 2007. The Stepwise Approach for Managing Infants and Young Children (5 Years of Age and Younger) with Acute or Chronic Asthma and the Stepwise Approach for Managing Asthma in Adults and Children Older than 5 Years of Age can be located on the Paramount web site. The guidelines were readopted without changes August 2013.

- **“Standards of Medical Care for Patients with Diabetes Mellitus.”** American Diabetes Association (ADA), 2013 (Updated by ADA annually). The guideline was adopted February 2013.

- **“Recommended Childhood Immunization Schedule.”** This schedule has been released by the Centers for Disease Control and Prevention (CDC). The Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Family Physicians (AAFP) have endorsed this immunization schedule. For 2013, the Recommended Immunization Record for persons aged 0 through 18 years is replacing the two previous schedules, which were separated by ages 0 through 6 years and ages 7 years through 18 years. The immunization schedule was adopted April 2013.


- **Prenatal and Postpartum Care Guidelines** based on “Guidelines for Perinatal Care,” 7th Ed, American College of Obstetricians & Gynecology (ACOG) and AAP, Revised October 2012. The guidelines were adopted in August 2013.
• **Depression Guideline** based on the “Recommendation on Depression Screening in Adults, Adolescents and Children,” USPSTF 2009 and ProMedica’s Clinical Practice Guidelines for Depression. Two additions were recommended: If two-question screen is positive, use PHQ-9 EHR if available or, if PHQ-9 EHR is unavailable, consider using any of the following: Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire (GHQ), Center for Epidemiological Study Depression Scale (CES-D). The guideline was readopted with changes September 2013.

• **Heart Failure Guideline** American College of College Foundation (ACCF)/American Heart Association (AHA) *Guideline for the Management of Heart Failure* was released in February 2013. The guideline was developed in collaboration with the American Academy of Family Physicians, American College of Chest Physicians, Heart Rhythm Society, and International Society for Heart and Lung Transportation. The guideline was adopted November 2013.

• **Cholesterol Management Guideline** This guideline is based on the National Cholesterol Education Program’s ATP III Guidelines At-A-Glance Quick Desk Reference. These guidelines, published in May of 2001 and updated in July of 2004, represent the most current guideline. The NHLBI is currently in the process of embarking on a new vision to integrate the cardiovascular risk factors for hypertension, high blood cholesterol and obesity by creating the Cardiovascular Risk Reduction Clinical Practice Guidelines. There were three expert panels and three work groups formed to update the existing guidelines and examine cross-cutting issues: lifestyle interventions, risk assessment, and guidelines implementation. The initial draft has been completed, but is not yet released to the public. When released publicly, the guidelines will be presented to the MAC for review. The guideline was readopted June 2013.

• **Alcohol Guideline** This guideline is based on the National Institute on Alcohol Abuse and Alcoholism (NIAAA) publications “A Clinician’s Guide: Helping Patients Who Drink Too Much,” 2005; and “Pocket Guide for Alcohol Screening and Brief Intervention,” 2008. This was readopted September 2013. “Alcohol Screening and Brief Intervention for Youth: Practitioner’s Guide,” 2011; and “Pocket Guide for Alcohol Screening and Brief Intervention for Youth,” 2011 were also readopted in September 2013.

• **Healthcheck Guidelines** based on the Ohio Department of Medicaid (ODM) Healthcheck Guidelines. These were readopted September 2013.

• **Chronic Obstructive Pulmonary Disease Guideline** This guideline is based on “*Global Initiative for Chronic Obstructive Lung Disease (GOLD)*,” NHLBI/WHO, updated February 2013; including “Pocket Guide to COPD Diagnosis, Management and Prevention,” updated February 2013. This guideline was readopted November 2013.

• The **Tobacco Cessation Guideline** is based on the United States Preventive Services Task Force’s (USPSTF) April 2003 Smoking Cessation Clinical Practice Guideline. There have been no updates to the adult recommendations. On August 27, 2013, an update was released regarding the guideline for school-age children and adolescents. The child and adolescent guideline states: The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents (B recommendation). This guideline was readopted without changes in November 2013.

To view the guidelines, go to www.paramounthealthcare.com, click on “Provider;” then click on “Publications and Resources” then “Clinical Practice Guidelines.”
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 Paramount Advantage members and all Medicaid populations (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.

To view or print the Ohio Department of Health Lead Testing Requirements and Medical Management Recommendations for Children Under the Age of Six Years (Revised 8/2010), go to www.odh.ohio.gov. Click on “L” on the A-Z Index. Then select “Lead Poisoning - Children.” Under the picture click, on Ohio Lead Testing Requirements and Medical Management Recommendations.

For additional information on lead poisoning, please contact the Ohio Department of Health for Childhood Lead Poisoning Prevention at 877-LEAD-SAFE.

Helpful tips to increase blood lead screening rates:

- Implement well-child checklist 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
The Ohio Department of Medicaid (ODM) 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 newborn 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 Healthchek exams during sick and well visits
- Bill according to guideline
- Educate members on importance of well visits, immunizations, dental visits, and blood lead testing

ODM 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.
*HEDIS® is a registered trademark of the NCQA.

Correct billing of Healthchek/well visits is essential for Paramount to capture claims to improve accuracy of administrative rates and decrease visits to provider offices for chart review. When a Healthchek exam is completed during any visit, include at least one of these codes:

<table>
<thead>
<tr>
<th>Preventive Medicine (ICD-9 CM Diagnosis codes)</th>
<th>New Patient Service (CPT 4 - E/M codes)</th>
<th>Established Patient Service (CPT 4 - E/M codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20.2 V20.3 V20.31 V20.32 V70.0</td>
<td>99381 99382 99383</td>
<td>99391 99392 99393</td>
</tr>
<tr>
<td>V70.3 V70.5 V70.6 V70.8 V70.9</td>
<td>99384 99385 99461</td>
<td>99394 99395</td>
</tr>
</tbody>
</table>

For additional billing information and age-specific Well Child Exam forms, go to www.paramounthealthcare.com. Click “Providers,” then “Publications and Resources” then “Healthchek.” There you will find a non-inclusive Healthchek Coding Guide and Paramount Advantage Healthchek Program Guideline.

In the center of the screen are 17 age-specific Well Child Exam forms. These forms 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 ODM are met during a Healthchek exam.
PREGNATAL TO CRADLE (PTC) is a Pregnancy Care Reward Program for Paramount Advantage (PA) members who are pregnant or have delivered in the last 60 days. PA members who register for the program are eligible to earn a $25 Wal-Mart gift card for each trimester of their pregnancy if they complete a recommended number of perinatal care appointments and a postpartum visit 21-56 days after delivery (up to $100 in total gift cards). PA members can register by completing the self-mailing registration card found in each PTC brochure (example on page 15) or online at www.paramounthealthcare.com. All registrants will also be entered one time into a monthly diaper drawing for the chance to win a 4-week supply of Pampers. Three diaper winners are selected each month; one winner in each of our three statewide regions.

The program is marketed statewide through medical providers, FQHCs, community clinics, WIC, JFS, health departments, and new member packet mailings. In addition, PA members are identified and mailed PTC info via claims, UCM transportation request, Healthchek information, and Pregnancy Risk Assessments. Enrollment in this program is voluntary. PA members can sign-up by completing the brochure/registration form and mailing it to Paramount Advantage, or they can register online at www.paramounthealthcare.com.

Brochures are available by contacting your PA Provider Relations Representative.

**Frequently Asked Questions:**

**Do you have to be a PA member to participate in the PTC program?**
Yes, this is a PA-added member benefit, so all participants must be effective PA members to participate.

**What if someone is not a PA member at the start of their pregnancy?**
The program is divided into three-trimester and 1-postpartum segments; therefore members coming onto PA later in their pregnancy are still eligible to earn at least a portion of the gift cards. Only prenatal/postnatal claims billed to Paramount Advantage are counted toward the program requirements.
Registration

1) Tear off the registration form from the Prenatal to Cradle brochure.
2) Write your Advantage member information in the boxes below.
3) Pull off the wax tape strip and press the two sides of the registration form together to seal.
4) Mail your registration; no stamp is needed.

Please print clearly

ADVANTAGE ID NUMBER
MEMBER FIRST NAME
MEMBER LAST NAME
MEMBER ADDRESS                             APT OR LOT #
CITY STATE                ZIP
PHONE NUMBER

DATE OF LAST MENSTRUAL PERIOD
_____/_____/_____  (month / date / year)

Prenatal to Cradle

The most important gift you can give your baby is early and regular pregnancy care.

Tear here to remove registration form for mailing

Important Information
• Remember to schedule prenatal and postpartum appointments with your doctor, midwife or provider.
• Contact your County Department of Job and Family Services (CDJFS) to update any changes to your address or phone number.
• Gift cards are mailed to the most recent CDJFS address on file. Advantage is not responsible for lost or stolen gift cards.
• You must be a Paramount Advantage member at the time of your prenatal and after delivery (postpartum) appointment(s) to qualify for gift cards.
• Gift cards are processed electronically every 6 - 8 weeks based on claims from your medical provider’s office.
• Your Prenatal to Cradle registration must be received no later than 60 days after your delivery date.
Paramount Advantage Member’s Rights and Responsibilities

Your membership rights

As a member of Paramount Advantage you have the following rights:

- To receive all services that Paramount Advantage must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless Paramount Advantage has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or MCP must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing.
- To be able to get all MCP written member information from the MCP:
  - At no cost to you;
  - In the prevalent non-English languages of members in the MCP’s service area;
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from Paramount Advantage and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the healthcare provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on Paramount Advantage’s panel at least monthly. Paramount Advantage must send you something in writing that says who the new PCP is and the date the change began.
- To be free to carry out your rights and know that the MCP, the MCP’s providers or Ohio Department of Medicaid will not hold this against you.
- To know that the MCP must follow all federal and state laws and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman’s health provider on Paramount Advantage’s panel for covered women’s health services.
- To be able to get a second opinion from a qualified provider on Paramount Advantage’s panel. If a qualified provider is not able to see you, Paramount Advantage must set up a visit with a provider not on our panel.
- To get information about Paramount Advantage from us.
• 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.

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
312-886-2359
TTY 312-353-5693

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 E. Broad St., 30th Floor
Columbus, Ohio 43215
614-644-2703
1-866-227-6353
TTY 1-866-221-6700
Fax 614-752-6381

Members have the responsibility to:

• Provide, to the extent possible, information that Paramount Advantage and the participating providers need to care for you. Help your primary care provider (PCP) fill out current medical records by providing current prescriptions and your previous medical records.
• Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed upon with your PCP or specialists.
• Continue seeing your previous PCP until the transfer takes effect.
• Obtain medical services from your Paramount Advantage PCP.
• Treat your PCP and her/his staff in a polite and courteous manner.
• Treat your PCP with respect and dignity.
• Inform your PCP of any symptoms and problems, and to ask questions.
• Carry your 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 you have changes in name, address or eligibility.
• Schedule and keep appointments and be on time. Always call if you need to cancel or if you will be late.
• Although a PCP referral is not required, contact your PCP, or the doctor or facility taking your calls, before seeing a consultant/specialist. You do not need to contact your PCP before making appointments with obstetricians, gynecologists, certified nurse practitioners, certified nurse midwives, federally qualified health center/rural health clinic providers, family planning providers, ODADAS certified treatment centers, and ODMH certified community mental health centers.
• 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 the other patients in the office.
• Learn and follow the policies and procedures as outlined in this handbook.
• Continue following Paramount Advantage policies and procedures until disenrollment takes effect.
• Indicate to your doctor who you wish to designate to receive information regarding your health.
- Inform Paramount Advantage and your caseworker of any dependent to be added or removed from coverage.
- Contact your PCP as soon as possible if you have received emergency treatment and notify Paramount Advantage within 48 hours.
- Call the Member Services Department if you have a problem and need assistance.
**Paramount Commercial** Member Rights and Responsibilities - Ohio & Michigan

**PURPOSE:** To provide subscribers of Paramount commercial and marketplace (exchange) products 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. 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.
**Paramount Elite** 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.

Section 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (spoken in languages other than English, in sign language, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

¿Si usted necesita a un intérprete? Llame a Servicios a los Miembros en el 1-419-887-2525 o sin coste en el 1-800-462-3589.

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in large print, or other alternate formats if you need it and ask for it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan’s benefits that is accessible and appropriate for you.

Your doctors and other health care providers are also required to provide free language interpreter services if you ask for it. By law, you cannot be required to bring your own interpreter. You or your doctor may call Member Services for help in arranging for interpreter service (phone numbers are printed on the back cover of this booklet). It is best to plan for this before the health care visit when possible. You can also ask Member Services for an “I Speak...” card to carry with your membership card. An “I Speak...” card (“Hablo...” carta) shows the language you prefer to use when speaking about your health, and tells the health care provider to obtain an interpreter.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.
Section 1.2 We must treat you with dignity, fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, military status, gender orientation, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). **We do not require you to get referrals to go to network providers.**

As a plan member, you have the right to get appointments and covered services from the plan’s network of providers **within a reasonable amount of time.** This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don’t agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.
You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of Paramount Elite, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English as spoken by a qualified interpreter, in sign language, and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan’s network, see the Paramount Elite Provider Directory.
  - For a list of the pharmacies in the plan’s network, see the Paramount Elite Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our web site at [http://www.paramounthealthcare.com/medicareplans](http://www.paramounthealthcare.com/medicareplans).

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the Paramount Elite Evidence of Coverage booklet, January 1, 2014 through December 31, 2014.
Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand. This means getting the information in a language other than English as spoken by a qualified interpreter or in sign language, with no cost to you. (Also see Section 1.1 of this booklet.) You may call Member Services before an appointment for help to arrange interpreter assistance (phone numbers are printed on the back cover of this booklet). If you are asked to sign any forms or papers that you do not understand, you may ask for it to be read to you out loud in English or by a qualified interpreter.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

• To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

• To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

• The right to say “no.” You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

• To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

• Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

• Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

• Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

• Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
• Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

• If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
• If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state Department of Health. Ohio residents may file a complaint with the Ohio Department of Health at 614-466-3543. Michigan residents may file a complaint with the Michigan Attorney General at 1-877-765-8388. Your “power of attorney for health care” or other legally authorized person may also file this complaint if you are unable to do so. You also have the right to make this complaint with us by calling Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made
If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?
If it is about discrimination, call the Office for Civil Rights
If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?
If you believe you have been treated unfairly or your rights have not been respected, and it’s not about discrimination, you can get help dealing with the problem you are having:

• You can call Member Services (phone numbers are printed on the back cover of this booklet).
• You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
• Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

• You can call Member Services (phone numbers are printed on the back cover of this booklet).
• You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
  • You can contact Medicare.
  • You can visit the Medicare website to read or download the publication, Your Medicare Rights & Protections. (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
• Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
Section 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you need a free language interpreter, please make your doctor and other health care providers aware. It is best to plan for this before the health care visit when possible. For an “I Speak …” card (“Hablo …” carta) to show along with your membership card, call Member Services (phone numbers are printed on the back cover of this booklet).
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again. Or, repeat what your doctor, pharmacist or other provider said, and ask if you understand it right. This does not waste time. It is part of good health care.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** **As a plan member, you are responsible for these payments:**
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
• For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.

• If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  • If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.

• If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

• If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

• **Tell us if you move. If you are going to move, it’s important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).**

  • **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

  • **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you. Be sure to let your health care providers know about your move as well.

  • If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

• **Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.**

  • Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.

  • ¿Si usted necesita a un intérprete? Llame a Servicios a los Miembros en el 1-419-887-2525 o sin coste en el 1-800-462-3589.

  • For more information on how to reach us, including our mailing address, please see Chapter 2.
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, 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.