This year, Paramount Health Care has been recognized as one of the top 69 institutions to receive the Star Performer recognition for Own the Bone. Only sites that have achieved a seventy-five percent (75%) compliance rate with at least 5 of the 10 Own the Bone prevention measures qualify for this recognition, and Paramount continues to exceed the 90th percentile for eight of the ten measures. Since the program’s inception, Paramount’s Osteoporosis Condition Management Program, a model of Own the Bone, has identified over eight hundred twenty-one (821) members with fragility fractures maintaining an eight-three percent (83%) participation and has made a significant increase in the overall compliance for BMD testing and pharmacotherapy recommendations.
Prescription Drug Changes for 2016

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 and the 2016 Formulary for Exchanges. These new lists are available on our website: www.paramounthealthcare.com/preferred-drug-lists.

How do Commercial Pharmacy Benefits work?
Visit the Paramount website to access an online version of the 2016 Preferred Brand Drug List, and to learn more about our copay tiers, prior authorization and step therapy requirements, and other coverage limitations. This information is updated on the website yearly, and when changes are necessary as decided by Paramount’s Pharmacy & Therapeutics Working Group throughout the year.

How are drugs selected for Marketplace Exchanges?
Marketplace coverage must maintain compliance with Essential Health Benefit benchmarks of coverage, as determined by each state. Our Pharmacy and Therapeutics Working Group also reviews changes throughout the year. Paramount has a growing number of participants who use our Marketplace formulary. Details of coverage for these members is available on our website, along with helpful tools, such as prior authorization forms and criteria. The formulary is updated on the site monthly, and when changes are approved.

Who creates the Paramount Advantage Preferred Drug List?
The preferred drug list for Paramount’s Ohio Managed Medicaid product is determined through a consensus-based process with the State of Ohio’s Fee-for-Service formulary and with the four other Managed Care Plans’ preferred drug lists. Paramount’s Pharmacy and Therapeutics Working Group reviews and approves any changes made, as well as approves utilization management limits and criteria. Updates are posted to the website, and a new formulary list is posted quarterly or when changes are made.

Stay Up To Date with Drug Coverage Information

New Prescription Drug Program Bulletins Posted. Do you know where to look?
Announcements, change notices, and essential news for the care of your patients is frequently posted at our provider website. Today, you can find information about 2016 drug list changes for Paramount Commercial, Paramount Exchange, and Paramount Advantage benefits. We also provide links to forms and current information. These links and announcements are designed to help serve you and your needs. Bookmark our announcements page today!
http://www.paramounthealthcare.com/provnews

Paramount Elite

Formulary and Utilization Management (UM) Criteria
Prescription drug plan information for our Medicare Part D plan participants is also available on the Paramount website. Formulary listings, coverage limitations, and UM criteria are updated monthly. 2016 Paramount Elite Part D drug information can be found here: http://www.paramounthealthcare.com/medicareplans/2016/home/
ICD-10 became effective October 1, 2015 as mandated by the U.S. Department of Health and Human Services. Paramount has been accepting, processing and paying ICD-10 claims throughout the month of October and November. We continue to ensure that our systems, supporting business processes, policies and procedures are meeting standards and deadlines without interruption to day-to-day business practices.

Providers are reminded:

- Claims with date of service or date of discharge prior to 10/1/2015 must contain only ICD-9 codes
- Claims with date of service or date of discharge on or after 10/1/15 must contain only ICD-10 codes
- To avoid claim rejections, code accurately and to the highest specificity of ICD-10 codes
- For questions, please use existing means of contacting Paramount: via our Provider Call Center or your Provider Representative.

**Paramount Advantage: ICD-10 Gestation Diagnosis Codes Required on Delivery Claims**

Ohio Department of Medicaid (ODM) will require that all claims for a delivery procedure (mother’s claim, not child’s claim) with a date of service (outpatient and professional) or date of discharge (institutional) on or after October 1, 2015 contain the weeks of gestation ICD-10 diagnosis code. This billing requirement will be effective with the ICD-10 compliance date of 10/1/15. To allow providers six months to adjust to this ICD-10 billing requirement, the system logic to enforce this billing guidance will be set to post and pay starting 10/1/15, and then set to deny for date of service (outpatient and professional) or dates of discharge (institutional) on or after 4/1/16.

For detailed instructions, including appropriate ICD-10 codes for claims containing specific CPT and ICD-10 procedure codes, please refer to ODM’s Document at: [http://medicaid.ohio.gov/Portals/0/Providers/Billing/ICD10/Updates/ChildDeliveryandWeeksGestation.pdf](http://medicaid.ohio.gov/Portals/0/Providers/Billing/ICD10/Updates/ChildDeliveryandWeeksGestation.pdf)
Over the past several years, reports about annual HEDIS® (the Healthcare Effectiveness Data and Information Set) results have focused on trends – especially those where we have either excelled, or have sought your assistance to improve. Effective this year, NCQA has made substantial changes among the particular measures to be scored for health plan accreditation. Several have been retired as well, e.g., process measures replaced with outcome measures. The table below summarizes the newest indicators, and a couple others still of interest to most practitioners. For more information or if you have questions, please contact phcquality@promedica.org or your Provider Relations Representative.

<table>
<thead>
<tr>
<th>Category</th>
<th>Commercial HMO</th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunizations - Combo #10</td>
<td>45.99% ↓  ↓</td>
<td>24.57% ↓ ↓</td>
<td></td>
</tr>
<tr>
<td>Adolescent Immunizations - Combo #1</td>
<td>71.11% ↑ ↑</td>
<td>52.61% ↓ ↓</td>
<td></td>
</tr>
<tr>
<td>HPV for Female Adolescents</td>
<td>12.57% ↑ ↑</td>
<td>16.55% ↓ ↓</td>
<td></td>
</tr>
<tr>
<td><strong>Child Well Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight in Kids-Nutrition Counseling</td>
<td>67.92% ↓ ↑</td>
<td>51.34% ↓ ↓</td>
<td></td>
</tr>
<tr>
<td>Weight in Kids-Activity Counseling</td>
<td>65.23% ↓ ↑</td>
<td>48.91% ↓ ↑</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Well Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>63.32% ↑ ↑</td>
<td></td>
<td>68.61% ↓ ↑</td>
</tr>
<tr>
<td><strong>Pregnancy Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency &gt; 80% Expected Prenatal Visits</td>
<td>76.16% ↓ ↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Medication - 75% Compliance</td>
<td>40.78% ↓ ↓</td>
<td>27.18% ↓ ↓</td>
<td></td>
</tr>
<tr>
<td>Appropriate Antibiotics - Adult Bronchitis</td>
<td>19.01% ↑ ↓</td>
<td>19.41% ↑ ↓</td>
<td></td>
</tr>
<tr>
<td>COPD - Systemic Corticosteroid</td>
<td>68.42% ↓ ↑</td>
<td>73.41% ↓ ↑</td>
<td>73.39% ↓ ↑</td>
</tr>
<tr>
<td>COPD - Bronchodilator</td>
<td>91.43% ↑ ↑</td>
<td>83.56% ↓ ↓</td>
<td>65.32% ↑ ↓</td>
</tr>
<tr>
<td><strong>Cardiovascular Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>73.78% ↑ ↑</td>
<td>60.34% ↓ ↑</td>
<td>81.75% ↑ ↑</td>
</tr>
<tr>
<td><strong>Diabetes Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c Control &lt; 8%</td>
<td>65.21% ↑ ↑</td>
<td>45.01% ↓ ↓</td>
<td>78.10% ↓ ↑</td>
</tr>
<tr>
<td>Blood Pressure Control &lt;140/90</td>
<td>76.40% ↑ ↑</td>
<td>65.94% ↓ ↑</td>
<td>78.35% ↑ ↑</td>
</tr>
<tr>
<td><strong>Mental/Behavioral Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for Alcohol/Drug Dependency</td>
<td>12.71% ↓ ↓</td>
<td>9.61% ↓ ↓</td>
<td>2.80% ↑ ↓</td>
</tr>
<tr>
<td>Following Kids on ADHD Drugs: Initial</td>
<td>30.54% ↓ ↓</td>
<td>52.15% ↑ ↑</td>
<td></td>
</tr>
<tr>
<td>Following Kids on ADHD Drugs: Continued</td>
<td>38.89% ↓ ↓</td>
<td>63.82% ↑ ↑</td>
<td></td>
</tr>
<tr>
<td><strong>Musculoskeletal Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis Management</td>
<td>29.85% ↑ ↑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Elite (Medicare) members are generally more satisfied with the quality of their care and services than other members in other products.
- The highest composite score across all product lines is How Well Doctors Communicate. The lowest composite score is Getting Care Quickly.
- Members in all Paramount products rated the overall quality of their health care very high, for which we thank YOU-our providers!

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Delay in Enforcement of the Medicare Part D Prescriber Enrollment Requirement

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs (“Final Rule”) on May 23, 2014. On May 6, 2015 CMS published CMS-6107-IFC Medicare Program; Changes to the Requirements for Part D Prescribers, an interim final rule with comment (“IFC”) that made changes to the Final Rule (summarized further below). The IFC’s effective date is June 1, 2015. The revised prescriber enrollment requirement applicability date is January 1, 2016. We have a responsibility to enforce this crucial program integrity and basic quality assurance protection for Medicare Part D beneficiaries as soon as possible. However, we also have a responsibility to enforce this protection in a way that minimizes the potential for disrupting beneficiaries’ access to needed Part D medications and compromising continuity of care.

CMS is delaying enforcement of the requirements in 42 CFR § 423.120(c)(6) until June 1, 2016. This decision was made based on CMS’ analysis of current Part D prescriber enrollment trends, and the strong concerns expressed recently by Part D sponsors and pharmacy benefit managers (PBMs) about their ability to make the complex system enhancements needed to comply with the prescriber enrollment requirement due to the changes made by the IFC. In order to continue to make meaningful and measurable progress toward a minimally disruptive implementation of the Medicare Part D prescriber enrollment requirement, CMS strongly encourages Part D sponsors and their PBMs to begin outreach activities no later than January 1, 2016 in accordance with the guidance in Attachment A to this memo. These outreach activities will enhance CMS’ continuing prescriber outreach and ongoing monitoring of prescriber enrollment trends and potential beneficiary impact. This period will provide Part D sponsors and their PBMs with an opportunity to address potential enrollee impact and specific business considerations arising from prescriber enrollment trends. Such activities will in turn inform CMS’ ongoing outreach, monitoring, and implementation of the prescriber enrollment requirement. CMS appreciates the efforts of stakeholders to work cooperatively with the agency to implement the requirement in this manner. Before engaging in outreach activities, Medicare advantage organizations that include a Part D benefit should review additional CMS guidance, which we expect to release in the near future.

CMS also strongly encourages prescribers of Part D drugs (except those who meet the definition of “other authorized prescribers”) to submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) before January 1, 2016. This should provide the MACs with sufficient time to process the prescribers’ applications or opt out affidavits and thus prevent prescription drug claims from being denied by Part D plans beginning June 1, 2016. Prescribers can refer to the following CMS website to find their MAC: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFSCompliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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 are made by appropriate practitioners, ie: physicians - all types including medical, behavioral health, pharmacists, dentists, chiropractors, physical therapists and vision.
## 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 ALL PROVIDERS

<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>
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 2015:

- **Adult and Senior Preventive Care Guidelines** are based on U.S. Preventive Services Task Force (USPSTF) @ AHRQ Home/Clinical Information/U.S. Preventive Services Task Force recommendations. The guidelines were adopted with changes August 2015.

- **Pediatric Preventive Care Guidelines** are based on American Academy of Pediatrics (AAP) 2014 Guidelines. The guidelines were adopted with changes August 2015.

- **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 2015.

- **Standards of Medical Care for Patients with Diabetes Mellitus** this guideline is based on American Diabetes Association Position Statement: Standards of Medical Care in Diabetes – 2015. The Council also found two figures in the guidelines that can be used as a reference for treating diabetes: 2015 Type 2 Diabetes Management Therapies and Approach to Starting and Adjusting Insulin in Type 2 Diabetes. The guideline was adopted February 2015.

- **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. The immunization schedule was adopted June 2015.

- **Cholesterol Management Guideline** The 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. The recommendations are intended to provide strong-evidence based foundation for the treatment of cholesterol for the primary and secondary prevention of ASCVD in women and men. This guideline is not intended to be a comprehensive approach to lipid management but for the purposes other than ASCVD risk reduction. Adopted by Paramount, August 2015.

- **Hypertension Guideline** released by the ACC/AHA/ASH (American Society of Hypertension) the “Treatment of Hypertension in Patients with Coronary Artery Disease” 2015. This guideline addresses primary and secondary prevention for those individuals with CAD/CHF/and PAD. Adopted by Paramount August 2015.

- **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 2015.
• **Depression Guideline** based on the “Recommendation on Depression Screening in Adults, Adolescents and Children,” USPSTF 2009 and ProMedica’s Clinical Practice Guidelines for Depression. There are no changes to the guidelines, however the MAC recommended if the two question screening is positive using the PHQ-9 HER if available; if not available consider use the Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire (GHQ), Center for Epidemiological Study Depression Scale (CES-D). The guideline was readopted September 2015.

• **Heart Failure Guideline** this guideline is from the American College of College Foundation (ACCF)/American Heart Association (AHA) *Guideline for the Management of Heart Failure* 2013. The guideline was re-adopted in November 2015 along with the ProMedica Heart Failure Clinic Guideline for Medication Therapy algorithm.

• **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. “Alcohol Screening and Brief Intervention for Youth: Practitioner’s Guide,” 2011; and “Pocket Guide for Alcohol Screening and Brief Intervention for Youth,” 2011. These were also readopted in September 2015.

• **Healthcheck Guidelines** are based on the Ohio Department of Medicaid (ODM) Healthcheck Guidelines for the Paramount Advantage (Medicaid) population. These were readopted September 2015.

• **Chronic Obstructive Pulmonary Disease Guideline** This guideline is based on “Global Initiative for Chronic Obstructive Lung Disease (GOLD),” NHLBI/WHO, updated 2015; including “Pocket Guide to COPD Diagnosis, Management and Prevention,” updated 2015. This guideline was adopted November 2015.

• **The Tobacco Cessation Guideline** - Tobacco Cessation Guidelines are based on the US Preventive Services Task Force (USPSTF): The Adult Tobacco Cessation Guideline is based on the US Preventive Services Task Force (USPSTF) Recommendations 2015 update. The Tobacco Use in Children and Adolescents: Primary Care Interventions is based on the 2013 USPSTF Guideline. The Guidelines were adopted without changes November 2015.

To view the guidelines, go to www.paramounthealthcare.com, click on “Provider,” then click on “Publications and Resources” then “Clinical Practice Guidelines.”
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 at age 1, again at age 2, and when medically indicated)
- Laboratory Tests (When medically indicated)
- Dental Assessment

Provider 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 HEDIS®.
Healthchek/Well-Visit Billing Guidelines

Codes to identify Healthchek/well visits are listed below. Please note:

- **Retirement** of ICD-9 CM Diagnosis Codes effective **September 30, 2015**.
- **Implementation** of ICD-10 CM Diagnosis Codes effective **October 1, 2015**.
- CPT-4-E/M codes remain the same.

### Retired Codes effective September 30, 2015
Preventive Medicine (ICD-9 CM Diagnosis codes)

<table>
<thead>
<tr>
<th>V20.2</th>
<th>V20.31</th>
<th>V20.32</th>
<th>V70.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>V70.3</td>
<td>V70.5</td>
<td>V70.6</td>
<td>V70.8</td>
</tr>
<tr>
<td>V70.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Effective October 1, 2015
New Preventive Medicine Codes (ICD-10 CM Diagnosis codes)

<table>
<thead>
<tr>
<th>Z00.00</th>
<th>Z00.01</th>
<th>Z00.110</th>
<th>Z00.111</th>
<th>Z00.121</th>
<th>Z00.129</th>
<th>Z00.5</th>
<th>Z00.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z02.0</td>
<td>Z02.1</td>
<td>Z02.2</td>
<td>Z02.3</td>
<td>Z02.4</td>
<td>Z02.5</td>
<td>Z02.6</td>
<td>Z02.71</td>
</tr>
<tr>
<td>Z02.79</td>
<td>Z02.81</td>
<td>Z02.82</td>
<td>Z02.83</td>
<td>Z02.89</td>
<td>Z02.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>99381</th>
<th>99382</th>
<th>99383</th>
<th>99391</th>
<th>99392</th>
<th>99393</th>
</tr>
</thead>
<tbody>
<tr>
<td>99384</td>
<td>99385</td>
<td>99461</td>
<td>99394</td>
<td>99395</td>
<td></td>
</tr>
</tbody>
</table>

### Documentation of Healthchek Screening Services

All components of a complete Healthchek must be documented in the member’s medical record. Should a Healthchek examination be refused, this refusal and any given reasons for this refusal must be documented in the patient’s medical record.

The entire Healthchek Guideline is available on the Paramount web site at http://www.paramounthealthcare.com. Click on Providers, Publications and Resources, Healthchek then Paramount Advantage Healthchek Program. 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. A Healthchek power point presentation is also available and a great education piece for office staff.
PREGNAT 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 $50 Wal-Mart gift card for a postpartum visit 21-56 days after delivery (up to $125 in total gift cards). PA members can register by enrolling online at www.ParamountAdvantage.org or completing the self-mailing registration card found in each PTC brochure (example on page 13). 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 enrolling online at www.ParamountAdvantage.com or completing the brochure/registration form and mailing it to Paramount Advantage.

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.
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 (2) sides of the registration form together to seal.
4. Mail your registration; no stamp is needed.

OR
- You may register online at www.ParamountAdvantage.org.

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

The most important gift you can give your baby is early and regular pregnancy care.
• Remember to schedule and attend all your prenatal and postpartum appointments with your doctor, midwife or provider.
• Contact Paramount Advantage and your County Department of Job and Family Services (CDJFS) to update any changes to your address or phone number.

Paramount Advantage wants you and your baby to get a healthy start!
If you are pregnant and a Paramount Advantage member, sign up for Prenatal to Cradle and you can earn up to $125 in gift cards just for going to your prenatal and after delivery (postpartum) appointment(s).

How do I sign up?
• Complete the attached Prenatal to Cradle registration form then mail it to Paramount Advantage.
• You may also sign up online at www.ParamountAdvantage.org.
• Once you register, Paramount Advantage will track the number of prenatal and after delivery (postpartum) appointment(s) you attend.
• 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 and mailed from your local CDJFS office to the most recent address on file. Gift cards are mailed to the most recent address on file. You are responsible for all information entered on your registration form.
• Important Information: Rewards are subject to availability and may vary by market. Be sure to register at the Health Network News website.
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.

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, and when medically indicated.
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 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.
**Paramount Advantage** Member’s Rights and Responsibilities

**Member 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 directive 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 ODM 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.
- 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 twenty-four (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.

Members Have 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.
• members are encouraged to inform 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, OMA 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.
Paramount Commercial Member Rights and Responsibilities - Ohio & Michigan

PURPOSE: To provide subscribers of Paramount commercial of the product 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. Be treated with respect, recognition of their dignity and the need for privacy.
5. Make recommendations regarding the organization’s member rights and responsibilities policies.
6. Voice complaints or appeals about the health plan or care provided.

**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

**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 (phone numbers are printed on the back cover of this booklet).

**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 and in large print or other alternate formats.) If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **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 website at 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.
  • 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 this booklet.

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. Our plan does not restrict dialogue between practitioners and patients, nor do we direct practitioners to restrict information regarding your treatment options. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely. 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 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. 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 SHIP. 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/Pubs/pdf/11534.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.
**HMO Individual Exchange** Member’s Rights and Responsibilities

**Members’ Rights**

As a Member of Paramount, you have certain rights you can expect from Paramount and Paramount providers. You have the right to:

1. Receive information about Paramount, its services, providers and your rights and responsibilities.
2. Participate with your physicians in decision-making regarding your 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. Be treated with respect, recognition of your dignity and the need for privacy.
6. Make recommendations regarding Paramount’s Member rights and responsibilities policies.

**Members’ Responsibilities**

As a Member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

1. Provide to the extent possible information that Paramount and the Participating Providers need to care for you. Help your PCP fill out current medical records by providing current prescriptions and your previous medical records.
2. Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
3. Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.
Paramount MEDICAL POLICIES are on the INTERNET

Medical policies express our determination of whether a health service (e.g., test, drug, device or procedure) is proven to be effective based on the published clinical evidence. They are also used to decide whether a given health service is medically necessary. Services determined to be experimental, investigational, unproven, or not medically necessary by the clinical evidence are typically not covered.

Medical policies do not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Medical technology is continuously evolving so medical policies are developed as needed, are regularly reviewed and updated, and are subject to change without prior notice.

Medical policies can be highly technical and complex and are provided here for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are solely responsible for diagnosis, treatment and medical advice.

Go to www.paramounthealthcare.com, click on Provider, then click on Medical Policies.