FOCUS ON MEDICAL RECORDS:
“CHANGING TIMES”

We would like to start by saying THANK YOU to all the Paramount providers and staff who graciously assisted us with our 2014 HEDIS® medical record reviews. Your help was greatly appreciated!

As we move forward with the Medicaid expansion, electronic medical records, ICD-10 and other federal mandates, it is most important that we focus on our HEDIS® scores in an effort to continue to provide quality care for our members.

With that being said, you may be contacted by one of our Quality Improvement staff within the next few months to review your individual and/or group HEDIS® results. Staff will discuss where best practice performance or significant opportunities for improvement were noted.

NetworkNews

Paramount Advantage Continues the Following Services for New Moms

Three services for Mom-to-Be
Moms can sign up for three services while they are pregnant to keep mom and her baby healthy.

1.) Prenatal to Cradle Program
   Moms can earn up to $100 in gift cards for baby care items by seeing their doctor. When moms sign up for Prenatal to Cradle their name will be entered one time in a drawing for a chance to win a four week supply of pampers. Moms can call 1-888-296-0220 for more information.

2.) Free Home Visits for Mom and Baby
   After her new baby arrives she can receive two visits to her home by a nurse. Someone will talk with her to set up an appointment before she leaves the hospital. She can also call 1-419-887-2525 or 1-800-462-3589.

3.) A Survey to See if Mom is Feeling Blue
   An Edinburgh Postnatal Depression Scale Survey is mailed to moms two weeks after delivery. Along with the survey they will receive a cover letter explaining Postpartum Depression and the “baby blues”. Members are instructed to complete the survey and mail the original back to Paramount and call their prenatal provider if they score an 11 or above on the survey.
Reimbursement Incentive
ADD/ADHD Medication Follow-up Phone Call
Commercial and Advantage Product Lines

Successful medication therapy for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) is directly related to follow-up care.

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

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

<table>
<thead>
<tr>
<th>Criteria &amp; Coding – Phone Consultation for ADD/ADHD Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Specialties:</strong> Family Practice, Internal Medicine, Pediatrics, Behavioral Health, &amp; Neurology</td>
</tr>
<tr>
<td><strong>ICD9 Codes Required for Payment</strong></td>
</tr>
<tr>
<td>314.00</td>
</tr>
<tr>
<td>314.01</td>
</tr>
<tr>
<td><strong>Required CPT Code</strong></td>
</tr>
<tr>
<td>98965</td>
</tr>
<tr>
<td>98967</td>
</tr>
<tr>
<td>98968</td>
</tr>
<tr>
<td>(A telephone call from a physician/non-physician health care professional for consultation and/or medical management; simple and brief).</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
</tr>
<tr>
<td>Patient Chart documentation following phone call, include:</td>
</tr>
<tr>
<td>Date / Time / Length of Call</td>
</tr>
<tr>
<td>Summary of Discussion</td>
</tr>
<tr>
<td>Or, use the SCRIPT attached</td>
</tr>
<tr>
<td><strong>Reimbursement &amp; Co-payment</strong></td>
</tr>
<tr>
<td>$40.00 reimbursement per call for CPT codes 98966, 98967, 98968, 99441, 99442, 99443</td>
</tr>
<tr>
<td>No co-payment will be applied to the phone call</td>
</tr>
</tbody>
</table>

Questions: Contact your Provider Relations Representative at:
(419) 887-2535 or (800) 891-2542

ACE-I and ARB Treatment
*Myth vs. Fact*

An estimated 25.8 million Americans have diabetes and this number continues to increase at epidemic proportions. Paramount has a diabetic population of 10,543 members. These diabetics are at increased risk for other systemic illnesses which include hypertension, cardiovascular and chronic kidney disease. Physicians should encourage use of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin receptor blocker (ARB) in their patients with hypertension and diabetes who could benefit from the proven reno-protective properties of these medications.

<table>
<thead>
<tr>
<th>ACE Inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MYTH</strong></td>
</tr>
<tr>
<td>ACE inhibitors should be avoided in chronic kidney disease</td>
</tr>
<tr>
<td>ACE inhibitors are ineffective in African American patients.</td>
</tr>
<tr>
<td>ACE inhibitors should be discontinued if any rise in creatinine occurs after initiation.</td>
</tr>
<tr>
<td>ACE inhibitors should be stopped if any hyperkalemia develops.</td>
</tr>
<tr>
<td>ACE inhibitors obviate the need to test and monitor for proteinuria and microalbuminuria.</td>
</tr>
</tbody>
</table>

Please consider treatment with an ACE Inhibitor or ARB if you have a patient with diabetes and hypertension. Given the increasing incidence of diabetes, hypertension and chronic kidney disease - primary care physicians play a critical role in the early evaluation and intervention of patients at risk.
**Modifier PT for Colonoscopy**

**SUMMARY**
Correct Use of Modifier PT

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code Range</th>
<th>Copay / Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Colonoscopy or Flexible Sigmoidoscopy</td>
<td>CPT Codes: 45355 or 45330, ICD9 Diagnosis Codes: V10.05, V16.0, V76.41, V76.51, V76.52, V76.89, V76.9</td>
<td>No copay applies</td>
</tr>
</tbody>
</table>

**ADD/ADHD Follow-Up Telephone Visit**
(days 31-300 of treatment)

Name ___________________________  ID # ___________________________  Date ______________

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

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

2. Can you tell me why not? ________________________________________________________

   **If not yet filled, advise to fill script; repeat call in two weeks.**
   **If filled but stopped taking, encourage making an appointment to discuss.**

3. Have you noticed any improvement in symptoms and/or behavior?
   - Yes → In what way(s) ______________________________________________________
   - No → Stress the need to continue the medication. May want to consider making an appointment to discuss dose adjustment or a different medication.

4. How is your child tolerating the medication? ______________________________________
   - List any side effects mentioned _____________________________________________
   - Reinforce that many side effects disappear over time once the body adjusts to new medicines. If severe, schedule an appointment to discuss.

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

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

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

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

9. Do you have any questions?

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

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________
2013 Physician Satisfaction Survey Highlights

Paramount views this survey as critical to long-term success; reviews the results and establishes action plans when appropriate. The 2013 Physician Satisfaction Survey was conducted by DSS Research, starting November 2013. The response rate was 24.5% (372 surveys completed). Two-thirds of the responses were from physicians, the rest from office managers and other staff. Over 60% of the respondents work in Lucas County. Overall satisfaction with Paramount remains high at 92.2%, but is a significant decrease from 95.8% in 2011. Likelihood to recommend Paramount to patients also decreased significantly, from 94.2% in 2011 to 90.0% in 2013. The survey measured various programs and services including Case Management, Disease Management, Drug Formulary, Coordination of Care, the Paramount website and plan communication. The Paramount Medical Advisory Council formed plans to improve the survey and future results:

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A brief summary of this guidance is provided below:

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(CMS) has notified all Medicare Advantage plans, including Paramount Elite, that although the Advanced Beneficiary Notice (ABN) of non-coverage is appropriate for use in the FFS Medicare program, it is not applicable for Medicare Advantage plans. Medicare Advantage plans are required to follow the process noted in 42 CFR 422.568 and 422.572 regarding advance determinations of whether a service is covered prior to it being rendered. Per Medicare regulations (42CFR 422.105(a)) when an Paramount Elite member receives an item or service that is only covered upon referral or pre-authorization by a contracted provider, the enrollee cannot be financially responsible for more than the normal cost-sharing if the enrollee correctly identified himself or herself as an enrollee of the plan to the contracted provider prior to receiving the item or service. This limitation on liability under § 422.105(a) applies unless the contracted provider can show that the enrollee received prior notice that the item or service would only be covered if further action was taken by the enrollee. Such prior notice is the issuance of an organization determination by Paramount.

As a Paramount Elite provider if you believe an item or service may not be covered, you must advise the member to request a pre-service organization determination from Paramount or you can request the organization determination on the enrollee’s behalf.

Should you have any questions regarding these updates, please contact your Provider Relations Representative at 419-887-2535.
QUALITY IMPROVEMENT PROGRAM OVERVIEW

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The Quality Improvement Program provides a formal process by which Paramount and its participating providers and practitioners strive to continuously improve the level of care and service rendered to members and customers. It utilizes objective and subjective indicators to measure and evaluate the quality and safety of clinical services provided to members. The program addresses both medical and behavioral health care, and the degree to which they are coordinated. It defines the systematic approach used to identify, prioritize and pursue opportunities to improve services, and to resolve identified problems. The Quality Improvement Program is reviewed, updated and approved by the Medical Advisory Council and forwarded to the Board of Directors at least annually. It is distributed to applicable regulatory bodies and other stakeholders, as requested.

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• To annually evaluate the efficiency and effectiveness of the Quality Improvement Program, including its structure, methodology, and results
• To evaluate at least annually the efficiency and effectiveness of performance from any subcontracted agents or service providers, also known as delegated entities
• To assure that all members are treated with dignity and respect, and are provided with appropriate, understandable education and information to accept responsibility and actively participate in personal health care decisions
• To use evidence-based guidelines as the basis for all clinical decision-making
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Coordination of Care

Paramount would like to thank the Primary Care Providers (PCPs) who responded to our August 2013 survey and April 2014 re-survey regarding communication from Specialty Care Providers. 201 out of 650 PCP’s replied to the 2013 survey for a response rate of 31% while 137 out of 633 PCPs responded to the April 2014 survey (21.64% return rate).

Both survey results are consistent with the 2012 and 2013 Provider Satisfaction Survey’s conducted for Paramount by DSS Research. All the surveys indicate that physicians in most clinical specialties provide patient care feedback to PCPs most of the time. Exceptions to these generally favorable results are found in Behavioral Health and Obstetrics/Gynecology. Practitioners in these two clinical areas were contacted in October 2013 with this comparative information and urged to begin implementing some means of routine feedback to the PCP. A sample communication form was provided.

A Paramount team will continue to address communication between providers because we recognize that coordinating care with the PCP is in our member’s best interest and is consistent with HIPAA provisions on health care operations. Currently, a random survey is being planned for Behavior Health and possibly OB/GYN providers to help identify best practices along with concerns and/or issues. A root cause analysis will be conducted following the survey(s) and an intervention(s) will be identified and implemented. The importance of communicating diagnosis, treatment plans, findings and medications back to the PCP for continuity and coordination of care will be stressed.

Upper Respiratory Infections (URI) and Inappropriate Use of Antibiotics

Improper use of antibiotics is one of the main causes for the increase of drug resistant bacteria in the United States. The CDC reports that only 2% of URI cases are caused by bacterial infections that would actually respond to and warrant antibiotic treatment.¹

Improper use of antibiotics in children is of particular concern because they have the highest rates of antibiotic use. The Ohio Department of Medicaid has tasked Managed Care Plans to decrease the inappropriate use of antibiotics, and as such, Paramount has implemented the following:

On March 1, 2014, Paramount began to pend ALL Advantage claims for patients 3 months to 18 years of age with a primary diagnosis of URI (460 or 465) for review.

• Claims with URI diagnosis and no prescribed antibiotic will be released immediately for payment.

• If an antibiotic was prescribed, the medical record will be requested.
  - If the objective findings in the chart note support the diagnosis of a bacterial infection (e.g. Otitis Media 382, Acute Sinusitis 461, Acute Tonsillitis 463) the claim will be returned for rebilling with the more accurate diagnosis code requiring antibiotic treatment.
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Modifier PT for Colonoscopy

Modifier PT indicates that a colorectal cancer screening test was converted to a diagnostic test or therapeutic procedure.

Adding Modifier PT to all service lines related to the procedure when a screening colonoscopy or flexible sigmoidoscopy becomes a diagnostic service or therapeutic procedure (on the same date of service), will waive the deductible for the related surgical services. No copay will apply.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code Range</th>
<th>Copay / Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Colonoscopy or Flexible Sigmoidoscopy</td>
<td>CPT Codes: 45355 or 45330</td>
<td>No copay applies</td>
</tr>
<tr>
<td></td>
<td>ICD9 Diagnosis Codes: V10.05, V16.0, V76.41, V76.51, V76.52, V76.89, V76.9</td>
<td></td>
</tr>
<tr>
<td>Converted to diagnostic test or therapeutic procedure</td>
<td>CPT Codes: 45378-45392, 45331-45345, G0104-G0106, G0120-G0121, 74270</td>
<td></td>
</tr>
</tbody>
</table>

Add Modifier PT to all service lines related to the procedure.

SUMMARY
Correct Use of Modifier PT

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

2. Can you tell me why not?

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

3. Have you noticed any improvement in symptoms and/or behavior?
   Yes → In what way(s)
   No
   Stress the need to continue the medication. May want to consider making an appointment to discuss dose adjustment or a different medication.

4. How is your child tolerating the medication?
   List any side effects mentioned
   Reinforce that many side effects disappear over time once the body adjusts to new medicines. If severe, schedule an appointment to discuss.

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

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

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

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

9. Do you have any questions?

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

Name __________________________ ID # __________________________ Date ______________

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

Signature ____________________________________________________________________________
Physician/Advanced Practitioner Signature ____________________________________________
Reimbursement Incentive
ADD/ADHD Medication Follow-up Phone Call
Commercial and Advantage Product Lines

Successful medication therapy for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) is directly related to follow-up care.

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

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

Criteria & Coding – Phone Consultation for ADD/ADHD Therapy

<table>
<thead>
<tr>
<th>Eligible Specialties:</th>
<th>Family Practice, Internal Medicine, Pediatrics, Behavioral Health, &amp; Neurology</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD9 Codes Required for Payment</td>
<td>314.00 Attention Deficit Disorder without mention of hyperactivity</td>
</tr>
<tr>
<td></td>
<td>314.01 Attention Deficit Disorder with hyperactivity</td>
</tr>
<tr>
<td>Required CPT Code</td>
<td>98965 non-physician; 99441 physician (5-10 minutes)</td>
</tr>
<tr>
<td></td>
<td>98967 non-physician; 99442 physician (11-20 minutes)</td>
</tr>
<tr>
<td></td>
<td>98968 non-physician; 99443 physician (21-30 minutes)</td>
</tr>
<tr>
<td>(A telephone call from a physician/non-physician health care professional for consultation and/or medical management; simple and brief).</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Patient Chart documentation following phone call, include:</td>
</tr>
<tr>
<td></td>
<td>Date / Time / Length of Call</td>
</tr>
<tr>
<td></td>
<td>Summary of Discussion</td>
</tr>
<tr>
<td></td>
<td>Or, use the SCRIPT attached</td>
</tr>
<tr>
<td>Reimbursement &amp; Co-payment</td>
<td>$40.00 reimbursement per call for CPT codes 98966, 98967, 98968, 99441, 99442, 99443</td>
</tr>
<tr>
<td></td>
<td>No co-payment will be applied to the phone call</td>
</tr>
</tbody>
</table>

ACE Inhibitors

<table>
<thead>
<tr>
<th>MYTH</th>
<th>FACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitors should be avoided in chronic kidney disease</td>
<td>ACE inhibitors are reno-protective in both diabetic and non-diabetic kidney diseases, mild as well as advanced.</td>
</tr>
<tr>
<td>ACE inhibitors are ineffective in African American patients.</td>
<td>Although less potent antihypertensives as monotherapy, ACE inhibitors can be effective as part of the overall hypertensive treatment plan, and are reno-protective beyond their effects on blood pressure.</td>
</tr>
<tr>
<td>ACE inhibitors should be discontinued if any rise in creatinine occurs after initiation.</td>
<td>A rise in creatinine of up to 30% is acceptable.</td>
</tr>
<tr>
<td>ACE inhibitors should be stopped if any hyperkalemia develops.</td>
<td>Mild hyperkalemia (K&lt;5.6) can often be remedied by low potassium diet and discontinuation of drugs that decrease potassium excretion.</td>
</tr>
<tr>
<td>ACE inhibitors obviate the need to test and monitor for proteinuria and microalbuminuria.</td>
<td>Proteinuria and microalbuminuria are modifiable risk factors for renal failure; monitoring is an essential feature of preventive primary care medicine.</td>
</tr>
</tbody>
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ACE-I and ARB Treatment

Myth vs. Fact

An estimated 25.8 million Americans have diabetes and this number continues to increase at epidemic proportions. Paramount has a diabetic population of 10,543 members. These diabetics are at increased risk for other systemic illnesses which include hypertension, cardiovascular and chronic kidney disease. Physicians should encourage use of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin receptor blocker (ARB) in their patients with hypertension and diabetes who could benefit from the proven reno-protective properties of these medications.

Please consider treatment with an ACE inhibitor or ARB if you have a patient with diabetes and hypertension. Given the increasing incidence of diabetes, hypertension and chronic kidney disease - primary care physicians play a critical role in the early evaluation and intervention of patients at risk.
Three services for Mom-to-Be
Moms can sign up for three services while they are pregnant to keep mom and her baby healthy.

1.) Prenatal to Cradle Program
Moms can earn up to $100 in gift cards for baby care items by seeing their doctor. When moms sign up for Prenatal to Cradle their name will be entered one time in a drawing for a chance to win a four week supply of pampers. Moms can call 1-888-296-0220 for more information.

2.) Free Home Visits for Mom and Baby
After her new baby arrives she can receive two visits to her home by a nurse. Someone will talk with her to set up an appointment before she leaves the hospital. She can also call 1-419-887-2525 or 1-800-462-3589.

3.) A Survey to See if Mom is Feeling Blue
An Edinburgh Postnatal Depression Scale Survey is mailed to moms two weeks after delivery. Along with the survey they will receive a cover letter explaining Postpartum Depression and the “baby blues”. Members are instructed to complete the survey and mail the original back to Paramount and call their prenatal provider if they score an 11 or above on the survey.
**Focus on Medical Records: “Changing Times”**

We would like to start by saying THANK YOU to all the Paramount providers and staff who graciously assisted us with our 2014 HEDIS® medical record reviews. Your help was greatly appreciated!

As we move forward with the Medicaid expansion, electronic medical records, ICD-10 and other federal mandates, it is most important that we focus on our HEDIS® scores in an effort to continue to provide quality care for our members.

With that being said, you may be contacted by one of our Quality Improvement staff within the next few months to review your individual and/or group HEDIS® results. Staff will discuss where best practice performance or significant opportunities for improvement were noted.

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**Paramount Advantage Continues the Following Services for New Moms**

Three services for Mom-to-Be

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