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INTRODUCTION
SECTION 1.0
Dear Participating Paramount Advantage Provider:

This orientation manual is designed to acquaint you with Paramount’s policies and procedures. The manual covers a wide range of information. The documents listed below are a sample of the multiple provider resources that can be found online at paramounthealthcare.com. We will be happy to provide you hard copy information upon request.

- CLINICAL PRACTICE GUIDELINES
- CREDENTIALING POLICIES AND PROCEDURES
- MEMBER RIGHTS AND RESPONSIBILITIES
- QUALITY IMPROVEMENT PROGRAM DESCRIPTION
- UTILIZATION CRITERIA
- UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

If you have questions about Paramount Advantage, please feel free to call your designated representative at 419-887-2535 or 800-891-2542.

Sincerely,

Sue M. Kucinski, Director
Provider Contracting and Network Management
Overview of Paramount Advantage

Paramount Advantage is a Toledo-based Ohio Managed Care Plan (MCP) that provides healthcare coverage to Covered Families and Children (CFC) including Healthy Start and Healthy Families and Aged, Blind, or Disabled (ABD) Medicaid consumers in all counties in the State of Ohio. Paramount Advantage is a member of ProMedica and is accredited by the National Committee for Quality Assurance (NCQA).

Prior Authorization Requirements

Some procedures, diagnostic services and drugs require prior authorization for Paramount Advantage members.

Prior authorization is obtained by contacting Utilization Management at Paramount.
Phone: 419-887-2520 or 800-891-2520, Fax: 419-887-2028 or 866-214-2024

<table>
<thead>
<tr>
<th>Those services requiring prior authorization are designated with <strong>PA</strong></th>
<th>Those services requiring a prescription from the PCP are designated with <strong>Rx</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance and ambulette transportation (PA, except in emergency)</td>
<td>Nursing Facility Services (PA)</td>
</tr>
<tr>
<td>Diagnostic Services (Rx, some PA)</td>
<td>Outpatient Hospital Services (Rx, some PA)</td>
</tr>
<tr>
<td>DME/Medical Supplies (Rx, some PA)</td>
<td>Plastic Surgery (Some PA)</td>
</tr>
<tr>
<td>Home Health (PA)</td>
<td>Podiatry Services (Rx)</td>
</tr>
<tr>
<td>Hospice Care (PA)</td>
<td>PT and OT (Rx)</td>
</tr>
<tr>
<td>Inpatient Hospital Services (PA, except in emergency)</td>
<td>Speech and Hearing Services including hearing aids (Rx/PA for ST services beyond benefit limits)</td>
</tr>
</tbody>
</table>

Current prior authorization requirements may also be found at paramounthealthcare.com

Additional information on covered services and requirements may be obtained from provider inquiry:

419-887-2564 or 888-891-2564
Claims Submission

Paramount requires all providers to submit claims on an HCFA 1500 form. Claims should be received within 365 days from the date of service and mailed to:

Paramount
P.O. Box 497, Toledo, OH 43697-0497
Attn: Claims Department

Community Mental Health Centers and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) providers bill Ohio Medicaid.

Electronic Claims Submission

For questions on electronic claims submission or to become an electronic claim submitter, contact the ECS Helpline 419-887-2532.

Paramount’s Medicaid Provider Numbers effective July 1, 2013: 0077190 (CFC) and 0077188 (ABD): [This number will be needed for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to bill for the MCD wraparound payment.]

Pharmacy Benefit Administrator (PBM)
Express Scripts 800-763-5550
## Who to Call at Paramount

<table>
<thead>
<tr>
<th>Department</th>
<th>For</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Credentialing</strong></td>
<td>• New Provider Applications</td>
<td>419-887-2535</td>
<td>419-887-2021</td>
</tr>
<tr>
<td></td>
<td>• Recredentialing Questions</td>
<td>800-891-2542</td>
<td>855-896-0854</td>
</tr>
<tr>
<td><strong>Member Services</strong></td>
<td>• Member Questions</td>
<td>419-887-2525</td>
<td>419-887-2047</td>
</tr>
<tr>
<td></td>
<td>• PCP Change Requests</td>
<td>800-462-3589</td>
<td></td>
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<td></td>
<td></td>
<td>888-740-5670 TTY</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Inquiry</strong></td>
<td>• Member Benefits and Eligibility</td>
<td>419-887-2564</td>
<td>419-887-2014</td>
</tr>
<tr>
<td>8 a.m. – Noon</td>
<td>• Claim Status Inquiries</td>
<td>888-891-2564</td>
<td>419-887-2018</td>
</tr>
<tr>
<td>1 p.m. – 5 p.m.</td>
<td>• Claim Processing Issues</td>
<td></td>
<td>Member Eligibility and Benefits</td>
</tr>
<tr>
<td><strong>Provider Relations</strong></td>
<td>• Member Questions</td>
<td></td>
<td>866-768-5372</td>
</tr>
<tr>
<td><strong>Representatives</strong></td>
<td>• PCP Change Requests</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Utilization/Case Management</strong></td>
<td>• Education – Provider and Office Staff</td>
<td>419-887-2535</td>
<td>419-887-2021</td>
</tr>
<tr>
<td>8 a.m. – 6 p.m.</td>
<td>• Contract Issues</td>
<td>800-891-2542</td>
<td>855-896-0854</td>
</tr>
<tr>
<td><strong>Monday – Friday</strong></td>
<td>• Orientations/Webinars</td>
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<td>• Fee Schedules</td>
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<td></td>
<td>• New Product Participation Requests</td>
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<td></td>
<td>• Representative Office Visit Requests</td>
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</tr>
<tr>
<td><strong>Post-Stabilization</strong></td>
<td>• Obtaining In-Plan and Out-of-Plan</td>
<td>419-887-2520</td>
<td>419-887-2028</td>
</tr>
<tr>
<td><strong>Care Services</strong></td>
<td>Prior Authorizations</td>
<td>800-891-2520</td>
<td>866-214-2024</td>
</tr>
<tr>
<td></td>
<td>Pharmacy Prior Authorizations</td>
<td></td>
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<tr>
<td><strong>Behavioral Health</strong></td>
<td>Members needing mental health and/or</td>
<td>419-887-2525</td>
<td></td>
</tr>
<tr>
<td></td>
<td>substance abuse services may call</td>
<td>800-462-3589 Toll-Free</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Member Services</td>
<td></td>
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<tr>
<td></td>
<td>A member may self-refer directly to a</td>
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<tr>
<td></td>
<td>Community Mental Health Center or Ohio</td>
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<td></td>
<td>Department of Alcohol and Drug Addiction</td>
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<td></td>
<td>Services (ODADAS) facility,</td>
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<tr>
<td></td>
<td>which is a Medicaid provider.</td>
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<tr>
<td></td>
<td>Members may self-refer to participating</td>
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<tr>
<td></td>
<td>Behavioral Health providers.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>For questions regarding coverage of</td>
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<tr>
<td></td>
<td>post-stabilization care services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>provided to Paramount Advantage members</td>
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<tr>
<td></td>
<td>in the ER Department, call:</td>
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<tr>
<td></td>
<td>ProMedica Call Center</td>
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<td></td>
<td>24 hours/day, 7 days/week</td>
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<tr>
<td></td>
<td>419-291-5899</td>
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<td></td>
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<tr>
<td></td>
<td>800-234-8773</td>
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<tr>
<td></td>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ProMedica Call Center</strong></td>
<td>24 hours/day, 7 days/week</td>
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<tr>
<td></td>
<td>419-291-5899</td>
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<td></td>
<td>800-234-8773</td>
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</table>
24-Hour Call-In System (ProMedica Call Center)

As stated in Paramount Advantage marketing materials, the member’s primary care physician is available 24 hours a day, 7 days a week. If care is needed outside of the PCP's office hours, members are instructed to call their PCP or ProMedica Call Center at 419-291-5899 or 800-234-8773, TTY at 419-291-5579, or the Ohio Relay Service TTY at 800-750-0750.

The ProMedica Call Center 24-hour call-in system has been integrated with Paramount Advantage since the inception of the program. This system is staffed by specially trained registered nurses who will help the caller make an informed decision about what to do. The nurses use a computerized database of information to provide fast, reliable health-related information, from proper nutrition and exercise to recognizing the symptoms of a serious illness.

The nurses at ProMedica Call Center are authorized to direct Paramount Advantage members to an urgent care or emergency room. In situations where ProMedica Call Center is acting as the “on call service” or a member is unable to reach his or her PCP, nurses are authorized to direct Paramount Advantage members to an urgent care or emergency room. ProMedica Call Center will then notify Paramount and the primary care physician that this referral has been made.

A log is kept at ProMedica Call Center that includes the following information:

1. Identification of the member.
2. Date and time of the call.
3. Member's presenting problem.
4. Disposition of the contact.
5. PCP contact, if applicable.
6. Date and time of the physician response.
7. Name and title of the person taking the call.

ProMedica Call Center utilizes the AccessHealth Clinical Assessment and Education System protocols for determining and directing the caller to the appropriate care setting.
PARAMOUNT ADVANTAGE
SECTION 2.0

PARAMOUNT ADVANTAGE
Affiliate of ProMedica
<table>
<thead>
<tr>
<th><strong>MEDICAL / SURGICAL</strong></th>
<th><strong>PCP STANDARD</strong></th>
<th><strong>NON-PCP STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Assessments, Physicals or New Visits</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>Routine Follow-up Visits</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>Symptomatic Non-urgent Visits</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>Urgent Medical Problems</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>Serious Emergencies</td>
<td>Immediate Care</td>
<td>Immediate Care</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>DENTAL (Paramount Advantage only)</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Care</td>
<td>95% of members can access care within 60-90 days</td>
</tr>
<tr>
<td>Routine Follow-up</td>
<td>95% of members can access care within 14-45 days</td>
</tr>
<tr>
<td>Symptomatic / Non-Urgent</td>
<td>95% of members can access care within 7-14 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>95% of members can access care within 72 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>95% of members can access care within 24 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TELEPHONE ACCESS ALL PROVIDERS</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care After Hours</td>
<td>95% of members will find access to care after hours acceptable</td>
</tr>
<tr>
<td>Return Phone Calls from Provider Office During Office Hours</td>
<td>95% of members will find return phone calls during office hours to be acceptable</td>
</tr>
</tbody>
</table>
Chiropractic Services – Outpatient

Limits of coverage for outpatient chiropractic services for Paramount Advantage members are in line with Ohio Medicaid limits and are as follows:

Coverage Limits
- 0-20 years – 30 visits per 12-month period (One unit of service per date of service)*
- 21 years and older – 15 visits per 12-month period (One unit of service per date of service)*
- Only services considered active treatment for an acute condition are allowed.
- Diagnostic X-rays to determine the existence of a subluxation are covered with certain limitations. Two units of service are allowed during any 6-month period.

Not Covered
- E&M codes are not reimbursable.
- Repeat X-rays, other diagnostic tests and procedures for patients with chronic, permanent conditions are not covered services.
- Physical therapy should not be done in a chiropractic setting. PT services for Paramount members should be performed by licensed physical therapists in a participating facility.

*The 12-month period renews July 1 for most Advantage members.
CONSENT / CERTIFICATION FORM UPDATE

Sterilization, Hysterectomy, and Abortion Procedures

CHANGE in Hysterectomy and Sterilization Form

ODJFS announced 5-14-12 that according to rule 5101:3-21-02.2, new forms for sterilization and hysterectomy are coming into effect July 1, 2012.

The changes are summarized in the table below.

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>DISCONTINUED ODJFS FORM</th>
<th>NEW ODJFS FORMS 7-1-12</th>
<th>FORM AVAILABLE AT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HYSTERECTOMY</td>
<td>JFS 03199 (rev. 7/2009)</td>
<td>JFS 03199 (rev. 4/2011)</td>
<td><a href="http://www.odjfs.state.oh.us/forms">www.odjfs.state.oh.us/forms</a></td>
</tr>
<tr>
<td></td>
<td>Discontinued as of 6-30-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discontinued as of 6-30-12</td>
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</tr>
</tbody>
</table>

2009 forms submitted after July 1, 2012 will be accepted ONLY if the patient’s signature was dated prior to June 30, 2012.

Please refer to Consent / Certification Form Instructions (7-3-12) when completing forms.

AUDIENCE: Surgeons, Ob/Gyn, Urology, FP, Anesthesia (Update to Bulletin of 8-24-09)

7-3-12
## CORRECT COMPLETION OF FORMS

<table>
<thead>
<tr>
<th>ALL FORMS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete the appropriate form (Abortion JFS 03197 (Rev. 3/05), Hysterectomy JFS 03199 (Rev. 4/11), Sterilization HHS 687 (5/10) English / HHS 687-1 (11/06) Spanish).</td>
<td></td>
</tr>
<tr>
<td>• A form is required when Paramount Advantage is primary or secondary.</td>
<td></td>
</tr>
<tr>
<td>• Incomplete forms will be returned and all associated claims from all providers will be denied.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STERILIZATION FORM</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Completed, signed, and dated 30 days prior to but within 180 days of the procedure.</td>
<td></td>
</tr>
<tr>
<td>• Patient must be at least 21 years of age.</td>
<td></td>
</tr>
<tr>
<td>• Sterilization post hysterectomy: submit medical records indicating prior sterility.</td>
<td></td>
</tr>
<tr>
<td>• In facility section, include complete name and address.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HYSTERECTOMY &amp; ABORTION FORM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid number for the provider and/or the patient when required can be found on Provider Direct.</td>
<td></td>
</tr>
<tr>
<td>• Abortion procedure codes – submit medical records for review.</td>
<td></td>
</tr>
</tbody>
</table>

## PRE-NOTIFICATION - CONTACT UTILIZATION / CASE MANAGEMENT

Surgeons must notify Paramount of the procedure date and if the original date changes.

Pre-notification eliminates the need for pre-authorization and facilitates more efficient processing of your claim according to Medicaid guidelines.  
(419) 887-2520 Option 3 or 1 (800) 891-2520

## CONSENT FORM, COVER SHEET & MEDICAL RECORD SUBMISSION

Faxing the form at the time of electronic submission will not delay processing of the claim.  
Fax: (419) 887-2530 Mail: Paramount, P.O. Box 928, Toledo, OH 43697-0928

### MISSING OR INCOMPLETE FORMS WILL RESULT IN A DENIAL

<table>
<thead>
<tr>
<th>EXPLAIN CODES:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BG - REQUIRED COMPLETED CONSENT/CERT FORM MISSING</td>
<td>SUBMIT ADJ No patient liability</td>
</tr>
<tr>
<td>BI - INCOMPLETE CONSENT/CERT FORM – SEND COMPLETED FORM W/ADJ</td>
<td>No patient liability</td>
</tr>
<tr>
<td>BJ - OAC 5101 RULE REQUIREMENTS NOT MET – CANNOT RESUBMIT</td>
<td>No patient liability</td>
</tr>
<tr>
<td>BM - AGE &lt;21 NO COVERAGE FOR STERILIZATION/OAC 5101</td>
<td>No patient liability</td>
</tr>
<tr>
<td>4K - RESUBMIT/USE CONSENT FORM IN EFFECT PER ODJFS</td>
<td>No patient liability</td>
</tr>
</tbody>
</table>

### CLAIRM ADJUSTMENTS AFTER A DENIAL

- Only the BG, BI, and 4K denials will be reconsidered.
- Complete an Adjustment Request Form, check appropriate procedure box, and include Consent/Certification Form with the Cover Sheet.

## QUESTIONS - CALL PROVIDER INQUIRY at: (419) 887-2564 or 1 (888) 891-2564

AUDIENCE: Surgeons, Ob/Gyn, Urology, FP, Anesthesia (Update to Bulletin of 8-24-09)
COVER SHEET FOR CONSENT FORM

Use FAX # (419) 794-0016 for CONSENT FORMS ONLY

<table>
<thead>
<tr>
<th>Member Name</th>
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<tbody>
<tr>
<td>Member Number</td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td></td>
</tr>
<tr>
<td>Provider Number</td>
<td></td>
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</tbody>
</table>

DOCUMENT TYPE 238

REV 08/19_16
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I have asked for and received information about sterilization from ____________________________ . When I first asked ____________________________ for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ____________________________ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: ____________________________

I, ____________________________ , hereby consent of my own free will to be sterilized by ____________________________ , My doctor or clinic, by a method called ____________________________ , My sterilization method.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or employees of programs funded by the Department of Health and Human Services.

I have received a copy of this form.

__________________________ ____________________________
Signature Date

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

□ Hispanic or Latino
□ Not Hispanic or Latino

□ American Indian or Alaska Native
□ Asian

□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White

□ Other: ____________________________

__________________________ ____________________________
Interpreter's Signature Date

PHYSICIAN'S STATEMENT

Before ____________________________ signed the ____________________________ consent form, I explained to him/her the nature of sterilization operation ____________________________ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

__________________________ ____________________________
Signature of Person Obtaining Consent Date

__________________________ ____________________________
Facility Date

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon ____________________________ on ____________________________ , I explained to him/her the nature of the sterilization operation ____________________________ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

__________________________ ____________________________
Name of Individual Date of Sterilization

__________________________ ____________________________
Specify Type of Operation

__________________________ ____________________________
Interpreter's Signature Date

__________________________ ____________________________
Physician's Signature Date

(paramounthealthcare.com)
CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información de __________________________ (médico o clínica) sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizado/a es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decidí no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F.D.C. o Medicaid, que recibo actualmente o para los cuales será elegible.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que sé esterilizada/o por medio de una operación conocida como __________________________. Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas. Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el: __________________________ (día, mes, año), por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por __________________________ (médico) por el método llamado __________________________ vencen 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

________________________ (firma de la persona que obtiene el consentimiento) __________________________ (fecha)

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo: (Definición de raza y origen étnico)

- Raza (marque según aplique):
  - Raza (marque según aplique):
    - 1.001 Hispano o latino
    - 1.002 Indígena americano o indígena de Alaska
    - 1.003 Asiático
    - 1.004 Negro o afroamericano
    - 1.005 Natural de Hawai u otras islas del Pacífico
    - 1.006 Blanco

- Origen étnico: __________________________

- 2.001 Investiga con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

■ DECLARACIÓN DEL MÉDICO ■

Previamente a realizar la operación para la esterilización a __________________________ (nombre de persona esterilizada/o) en __________________________ (fecha de esterilización), el hecho de que la esterilización es diferente porque es permanente.

Le informó a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene de los menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.

■ DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO ■

Antes de que __________________________ (nombre de persona) firme la Forma de Consentimiento para la Esterilización, le he explicado a ella/el los detalles de la operación de __________________________ (nombre del médico) que se presenta a continuación.

(1) Han transcurrido por lo menos 30 días desde la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

□ Cirugía abdominal de urgencia (Describa las circunstancias):

□ Parto prematuro Fecha prevista de parto: __________________________

□ Raza (marque según aplique):
  - 2.001 Raza (marque según aplique):
    - 1.001 Hispano o latino
    - 1.002 Indígena americano o indígena de Alaska
    - 1.003 Asiático
    - 1.004 Negro o afroamericano
    - 1.005 Natural de Hawai u otras islas del Pacífico
    - 1.006 Blanco

□ Ocupación: __________________________ (especifique tipo de operación)

□ Estado de salud: __________________________

□ Participación en programas de espionaje:
  - 3.001 Participación en programas de espionaje:
    - 1.001 No participó
    - 1.002 Participó

HHS-687-1 (11/2006)
Ohio Department of Job and Family Services

ACKNOWLEDGMENT OF Hysterectomy INFORMATION

Instructions: Complete Section I and either Section II or Section III.

Section I: Patient Information (REQUIRED: please type or print clearly)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name</td>
<td></td>
</tr>
<tr>
<td>Name of Patient's Representative (if any)</td>
<td></td>
</tr>
<tr>
<td>Patient's 12 Digit Medicaid Number</td>
<td></td>
</tr>
<tr>
<td>Date of Hysterectomy</td>
<td></td>
</tr>
</tbody>
</table>

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)

Patient acknowledgement of receipt of hysterectomy information:
I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be has not been performed solely for the purpose of making me incapable of reproducing (sterile).

Prior to the hysterectomy, I have been/was informed, both orally and in writing, that the hysterectomy would make me permanently incapable of reproducing (sterile).

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Representative Signature</td>
<td></td>
</tr>
<tr>
<td>Date of Signature</td>
<td></td>
</tr>
</tbody>
</table>

Provider acknowledgement of provision of hysterectomy information:
Prior to the hysterectomy, I informed this patient (and her authorized representative, if applicable) both orally and in writing, that the hysterectomy would make her permanently incapable of reproducing (sterile).

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Person Providing Information</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Providing Information</td>
<td></td>
</tr>
<tr>
<td>Date of Signature</td>
<td></td>
</tr>
</tbody>
</table>

Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.

Prior to the hysterectomy, the patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: (check all that apply, please type or print clearly, do not provide additional attachments)

- ☐ she was already sterile before the hysterectomy (please briefly explain cause of the sterility):

- ☐ the hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible (please describe the nature of the emergency):

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the physician who performed the hysterectomy (please type or print clearly)</td>
<td></td>
</tr>
<tr>
<td>Signature of the physician who performed the hysterectomy</td>
<td></td>
</tr>
<tr>
<td>Date of Signature</td>
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</tr>
</tbody>
</table>

FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES
Ohio Department of Job and Family Services
ABORTION CERTIFICATION FORM

I certify that, on the basis of my professional judgment, this service was necessary because (check one box only)

- 1. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

- 3. The pregnancy was the result of an act of rape and the patient, the patient’s legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or

- 4. The pregnancy was the result of an act of incest and the patient, the patient’s legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or

- 5. The pregnancy was a result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or

- 6. The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

PLEASE NOTE: The number indicators beside the empty boxes are for departmental use only.

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Physician's Name (Please Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Address</td>
<td>Physician's Medicaid Provider Number</td>
</tr>
<tr>
<td>City, State, and Zip Code</td>
<td>Physician's Signature</td>
</tr>
<tr>
<td>Patient's Medicaid Billing Number</td>
<td>Date</td>
</tr>
</tbody>
</table>

OAC 5101:3-17-01 requires completion of this form in order to receive Medicaid reimbursement.

JFS 03197 (Rev. 3/2005)
Diabetes Quality Incentive Program

Paramount initiated its Diabetes Quality Incentive Program in 2009. The focus of the program is to provide quality care to our members with diabetes eighteen years of age or older. The program rewards Primary Care Physicians and Endocrinologists when members are in control according to five diabetes control measures.

1. A1C < 8.0%
2. Blood Pressure
   - Systolic < 140
   - Diastolic < 80
3. LDL Cholesterol < 100mg/dl
4. ACE or ARB Therapy or Nephrology Visit
5. Dilated Eye Exam

Paramount will determine diabetes control for a member for three of the five criteria (A1C, Blood Pressure, LDL) when the provider reports control using Category II reporting codes on the CMS 1500. Paramount will determine the remaining criteria compliance internally through pharmacy and claims data.

The program challenge period covers service dates for the current calendar year starting January 1 through December 31. Providers may earn from $150 (when 4 control criteria are met) to $200 (when all 5 control criteria are met) per patient per measurement year. The reward will be paid once per measurement year in spring to allow for claims processing.

At the beginning of each calendar year Paramount will provide each PCP and Endocrinologist a packet with detailed instructions and a list of members with diabetes that we have identified.

Providers may go to paramounthealthcare.com/providerincentives for complete information and to print forms related to the program.

With questions, please contact Marcia Kasza in Provider Relations at marcia.kasza@promedica.org or call 419-887-2854 or (800) 891-2542.
As a Paramount Provider, you are **required by Federal law** to provide language assistance when requested, or when you believe it will ensure a satisfactory health care encounter.

- You may **not** require a patient to provide his/her own interpreter.
- The service must be **free** to the patient.
- It is **never acceptable** to involve a minor child in health care interpreting.
- If a patient wants to bring his/her own interpreter it is recommended you also arrange for a qualified medical interpreter.

**Paramount Member Services** can coordinate interpreter services prior to a health care visit at no cost to the provider or the member. This benefit is available to any provider with a need for language assistance by calling the appropriate number listed below. When a member is identified with a language need, please inform Member Services to update the member record.

**Qualified Resources to Assist Providers**

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

**For Assistance in Arranging Language Services, Contact...**

| Paramount Member Services | Paramount Advantage: 7am – 7pm, M-F | (419) 887-2525 or (800) 462-3589 |
|--------------------------|--------------------------------------|________________________________|
|                          | Paramount Elite: 8am – 8pm, M-F; October 1 – February 14, 8am – 8pm seven days per week |
|                          | HMO Members: 8am – 5pm, M-F          | TTY (419) 887-2526 or (888) 740-5670 |
| ProMedica Call Center    | 24/7 Availability                    | Ask Paramount (877) 336-1616 |
| (For after hour assistance) |                                      | TTY (419) 291-5579 or (888) 542-3886 |

**Ohio Relay Services (ORS)**

Free service for deaf, hard-of-hearing, deaf-blind and speech-disabled people. Conversations are relayed using Text Telephone (TTY), or in some cases, verbally to hearing parties.

<table>
<thead>
<tr>
<th>Contact ORS</th>
<th>24/7 Availability</th>
<th>(800) 750-0750</th>
</tr>
</thead>
</table>

*Revised 2/2013*
**Lead Testing Requirements and Medical Management Recommendations for Children Under the Age of Six Years**

_revised 8/2010_

Ohio Department of Health • Bureau of Child and Family Health Services
Ohio Healthy Homes and Lead Poisoning Prevention Program • www.odh.ohio.gov

**There is no safe level of lead in the blood.**

Any confirmed level of lead in the blood is a reliable indicator that the child has been exposed to lead.

All blood lead test results, by law, are required to be reported to ODH by the analyzing laboratory.

---

### Lead Testing Requirements

1) Is the child on Medicaid?
   - If yes, **TEST AT AGES 1 AND 2 — IT’S OHIO LAW!** (OAC Rule 5101:3-14-03).

2) Does the child live in a High Risk ZIP Code? (see list on back or visit [http://www.odh.ohio.gov](http://www.odh.ohio.gov))
   - If yes, **TEST— IT’S OHIO LAW!**

3) Ask the parent these five key questions to assess the child’s risk.
   - Does your child:
     - Live in or regularly visit a house built before 1950? This includes a day care center, preschool, or home of a baby sitter or relative.
     - Live in or visit a house that has peeling, chipping, dusting or chalking paint?
     - Live in or visit a house built before 1978 with recent, ongoing, or planned renovation/remodeling?
     - Have a sibling or playmate who has or did have lead poisoning?
     - Frequently come in contact with an adult who has a hobby or works with lead? Examples are construction, welding, pottery, painting, and casting ammunition.

   If the family answers “yes” or “do not know” to any of the above questions, **TEST— It’s Ohio law.**

   If the family answers “no,” provide prevention guidance and follow up at the next visit.

---

### Blood Lead Levels (BLL) and Medical Management Recommendations

<table>
<thead>
<tr>
<th>BLL (µg/dL)</th>
<th>Medical Management Recommendations</th>
</tr>
</thead>
</table>
| <5         | • Provide anticipatory guidance during well child care visits at 6, 9 and 12 months: discuss sources, effects of lead and hazards associated with renovating pre 1978 homes.  
• Test blood lead level (BLL) again in 12 months. |
| 5–9        | In addition to medical management actions listed above: explain child’s BLL and how to reduce exposure and absorption.  
• Explain that there is no safe level of lead in the blood.  
• Discuss wet cleaning to remove lead dust on surfaces; eliminating access to deteriorating lead paint surfaces; and ensuring regular meals that are low in fat and rich in calcium and iron.  
• Refer to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) or for other nutritional counseling.  
• Parent may hire licensed personnel to conduct a lead risk assessment to determine source of exposure. |
| 10–19      | In addition to medical management actions listed above:  
• Confirm capillary results by venous or second capillary blood sample within one month.  
• When results are confirmed, test BLL again in two months. If BLL persists in this level (i.e., two confirmed tests ≥10µg/dl at least two months apart), proceed according to actions for BLL 20–44.  
• Refer to Help Me Grow program if appropriate.  
• Test BLL every one-two months until the BLL remains <10µg/dl for at least six months and lead hazards have been removed or made lead safe and no new exposure exists.  
State or local health department will conduct a public health lead investigation and provide case management. |
| 20–44      | In addition to medical management actions listed above:  
• Take medical, environmental and nutritional Hx; test for anemia and iron deficiency; assess neurologic, psychosocial and language development; screen all siblings under 6; and evaluate risk of other family members (e.g., pregnant women).  
• Refer to the Bureau for Children with Medical Handicaps (BCMH) program, if appropriate. |
| ≥45        | In addition to medical management actions listed above:  
• Confirm fingerstick (capillary) results by venous blood sample immediately. A venous specimen will ensure therapy is based on current and reliable information.  
• Chelation therapy is indicated if venous testing confirms level.  
• Immediately remove child from exposure source. |

---

**ODH Information and Referrals**

**Help Me Grow Hotline:** 1-800-755-GROW (1-800-755-4769)  
**Bureau of Early Intervention (EI):** 614-644-8389  
**Bureau Children with Medical Handicaps (BCMH):** 614-466-1700  
**Women, Infants and Children (WIC):** 614-466-4110  
**Medicaid Provider Hotline:** 800-686-1516  
**ODH OHHLPPP:** 614-466-5332  

State of Ohio (DOH) • 8/10 • 7M@.132
# High Risk ZIP Codes

**Requiring Blood Lead Testing**

for children under the age of six years, as Ohio law designates

Ohio Department of Health • Bureau of Child and Family Health Services

Ohio Healthy Homes and Lead Poisoning Prevention Program (OHHLPPP)

<table>
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<th>County</th>
<th>ZIP Code</th>
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*Based on Ohio Department of Administrative Services 2001.*

**The Lead Risk Model used to determine the High Risk ZIP codes was developed by The Ohio State University, Center for Bioscience.**

2000 Census data and 2001 blood lead data were used to locate hot census tracts, which were then overlaid with ZIP code boundaries. A ZIP code with any part of a hot census tract is considered to be at high risk.

The variables used in the Lead Risk Model include:

- **Housing conditions:**
  - At least 15% of children tested in that census tract have BLL 10µg/dL or higher
  - Housing environment
  - Demographic characteristics
  - Socioeconomic
  - Housing density and % public assistance

*Based on Ohio Department of Administrative Services 2001.*
Prenatal Risk Assessment Form Guidelines

1. The Prenatal Risk Assessment (PRA) form, JFS 03535, is a checklist of medical and social factors which is used as a guideline to determine when a patient is at risk of preterm birth or poor pregnancy outcome.

2. The PRA form must be completed on each obstetrical patient during the initial antepartum visit in order to bill for the prenatal at-risk assessment code. A copy of the PRA form should be placed in the patient's record to serve as documentation that the service was provided.

3. Providers must submit a copy of the PRA form to the patient's residential county department of Medicaid since the county staff can assist patients obtaining needed services.

4. When significant risk factors that were not noted on the original PRA form are identified during the course of the pregnancy, providers are encouraged to complete another risk assessment form and to send a copy to the county department of Medicaid.

5. Providers may receive reimbursement for completing the PRA form by billing the code for prenatal risk assessment specified in rule 5101:3-4-10 of the Administrative Code (H1000).

Please see form on next page.
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
PRENATAL RISK ASSESSMENT FORM

Please print or type:

Patient Name

Case/Recipient Number

Expected Date of Delivery (EDD): month / day / year

Patient Address

Physician Name

Please circle Diagnostic Code for this assessment:

V22

V23

Patient Telephone

Physician Telephone

Case Name if different from patient name

Enrolled in Managed Care Plan (HMO):

Please circle

YES

NO

Please check all that apply:

Distribution: Original in provider file, Copy to CDJFS

AT RISK OF PRETERM BIRTH

If at least one factor is checked, patient is at risk of preterm birth - V23.8

OBSTETRICAL HISTORY

1. ABORTION, 1st or 2nd trimester, spontaneous or therapeutic

2. CONE BIOPSY

3. DES EXPOSURE

4. ECLAMPSIA OR SEVERE PREECLAMPSIA

5. INCOMPETENT CERVIX

6. LOW BIRTH WEIGHT, less than 2500 g

7. PRETERM DELIVERY/LABOR

CURRENT PREGNANCY

8. ABDOMINAL SURGERY

9. AGE, less than 19 or more than 35 years

10. ANEMIA, less than 11 hgb or less than 33% hct

11. ANEMIA, Sickle Cell or other hemoglobinopathy

12. ASTHMA, on medication

13. BLEEDING, if significant after 12 weeks

14. CERVIX DILATED, more than 1.5 cm before 29 weeks

15. CERVIX EFFACED, less than 1 cm before 29 weeks

16. CHRONIC BRONCHITIS

17. DIABETES, insulin dependent

18. DOMESTIC VIOLENCE

19. DRUG OR ALCOHOL ABUSE

20. ECLAMPSIA OR PREECLAMPSIA

21. HEART DISEASE

22. HYPERTENSION, on medication

23. IRRITABLE UTERUS

24. LATE INITIAL VISIT, after 14 weeks of pregnancy

25. MALIGNANCY OR LEUKEMIA

26. MISSED PREGNANT APPOINTMENTS

27. MULTIPLE GESTATION

28. OLIGOHYDRAMNIOS

29. PLACENTA PREVIA, 3rd trimester

30. PNEUMONIA

31. POLYHYDRAMNIOS

32. POOR NUTRITION

33. PRENATAL CARE NONCOMPLIANCE, most recent pregnancy

34. PRETERM LABOR

35. PROM, confirmed

36. KIDNEY DISEASE, UTI (urinary tract infections)

37. SMOKING

38. TRAUMA

39. UNDERWEIGHT

40. UTERINE ANOMALY OR FIBRONECTIN

41. WEIGHT LOSS

42. OTHER

AT RISK OF POOR PREGNANCY OUTCOME

If at least one factor is checked, patient is at risk of poor pregnancy outcome - V23.9

OBSTETRICAL HISTORY

43. CONGENITAL ANOMALY, major

44. INFANT DEATH; Stillborn, Neonatal, Post Neonatal

CURRENT PREGNANCY

45. ANESTHESIA RELATED ALLERGIES

46. DEEP VENOUS THROMBOSIS

47. DIABETES, GESTATIONAL, diet controlled

48. DRUG OR ALCOHOL ABUSE

49. EPILEPSY or on anticonvulsant

50. FAMILIAL GENETIC DISORDER, confirmed

51. GRAND MULTIPARA, more than 5 of 20 weeks or more

52. GROUP B STREPTOCOCCAL DISEASE

53. HEIGHT, less than 5 feet

54. HEPATITIS OR CHRONIC LIVER DISEASE

55. HIV / ARC / AIDS

56. ILLITERACY OR LANGUAGE BARRIER

57. ISOIMMUNIZATION associated with fetal disease

58. MENTAL RETARDATION

59. OBESITY, more than 20% weight for height

60. PRIOR C-SECTION

61. PSYCHOSIS, within past 5 years

62. RECENT DELIVERY, less than 1 year

63. RUBELLA EXPOSURE with rising titer

64. SEXUALLY TRANSMITTED DISEASE, any

65. THYROID DISEASE, confirmed

66. TUBERCULOSIS, active

67. OTHER

Physician's Signature

Date

JFS 93535 (Rev. 2/2003)

paramounthealthcare.com

2.15

Paramount Advantage V.6
Healthchek Program

Healthchek is Ohio's early and periodic screening, diagnosis and treatment (EPSDT) program. EPSDT is federally mandated health services for Medicaid-eligible persons from birth through 20 years of age. EPSDT is designated to maintain health by providing early intervention to discover and treat health problems.

The scope of services provided depends on the individual's age, gender, family medical history, ethnic background, or findings of the Healthchek (EPSDT) screening or other covered medical service, as specified in Chapter 5101:3-14 of the Administrative Code.

Healthchek services may also include medically necessary follow-up care including, but not limited to, laboratory tests, prescription drugs, clinic visits, inpatient or outpatient hospital care, and visits to physicians, dentists, optometrists, etc.

Healthchek screening services are composed of the components described in rule 5101:3-14-03 of the Administrative Code.

Healthchek services may also include medically necessary follow-up care including, but not limited to, laboratory tests, prescription drugs, clinic visits, inpatient or outpatient hospital care, and visits to physicians, dentists, optometrists, etc.

Healthchek screening services are composed of the components described in rule 5101:3-14-03 of the Administrative Code. And Healthchek diagnosis and treatment services, defined as medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, are composed of the components described in rule 5101:3-14-05 of the Administrative Code.

Definitions:

(1) For the purposes of Chapter 5101:3-14 of the Administrative Code, “screening” is defined as the identification of individuals at risk of health problems. Results of a screening do not represent a diagnosis, but rather, indicate need for referral to an appropriate resource for additional evaluation, diagnosis, treatment, or other follow-up when concerns or questions remain as a result of the screening.

Healthchek Screening Service Frequencies

Screening components of the Healthchek (EPSDT) visit shall be provided to individuals at ages and at frequencies in accordance with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care at www.aap.org. To assure members receive the appropriate number of well-visits, encounters are monitored by Ohio Department of Medicaid (MCD), formerly Ohio Department of Job and Family Services (ODJFS) and Paramount Advantage.

- Eight exams 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.

Healthchek Screening Services

This rule describes the screening components that the Healthchek (EPSDT) provider shall complete and document as part of initial and periodic Healthchek (EPSDT) screening visits, unless the individual, or the individual's parent or guardian, refuses the components. The provider shall document such a refusal.

(A) Comprehensive Health and Development History

(1) A “comprehensive health and development history” is a profile of the individual's medical history and includes a review of both physical and mental health development. The provider shall obtain the individual's medical history from the individual (if age-appropriate), the individual's parent or a responsible adult who is familiar with the individual's history.
(2) The provider shall obtain or update the comprehensive health and developmental history at each initial and periodic Healthchek (EPSDT) screening visit. The comprehensive health and developmental history shall include at a minimum:

(a) Current complaints/concerns;
(b) The individual’s and family’s history of illnesses, diseases and allergies;
(c) Current medications and adverse effects to medications;
(d) The individual’s social or physical environment that may affect the individual’s overall health; and
(e) For adolescents, the individual’s sexual activity and contraceptive methods.

(B) Comprehensive Unclothed Physical Examination
The provider shall perform a comprehensive unclothed physical examination during each initial and periodic screening visit. The examination shall include at a minimum:

(1) Measurements of height and weight, including comparisons of age-appropriate percentiles;
(2) Annual BMI percentile, calculated based on standing height and weight, documented on a body mass index – for age/sex growth chart for children ages 3-20 (For ages 16-20, documentation of a BMI value calculated as kg/m² is acceptable (HEDIS requirement);
(3) Blood pressure as age-appropriate;
(4) Head circumference, including percentiles, as age-appropriate;
(5) Examination of head, ears, eyes, nose, and throat; respiratory, cardiovascular, gastrointestinal, reproductive, musculoskeletal, and neurological systems;
(6) For age-appropriate females, a breast inspection and palpation, and instructions in breast self-examination;
(7) For age-appropriate males, testicular examination, and instructions in self-examination of the testes; and
(8) A pelvic examination may be provided for age-appropriate females as part of the Healthchek (EPSDT) screening visit when medically indicated.

(C) Developmental Screening (Including Physical and Mental Health Development)
The provider shall perform or update the developmental screening at each initial and periodic screening visit. The developmental screening shall include an age-appropriate developmental history and a screening of the individual’s motor, speech, mental, and social development.

(D) Nutritional Screening
The provider shall perform a screening of the individual’s nutritional status as part of the basic examination component of each initial and periodic Healthchek (EPSDT) screening visit through questions about dietary practices, measurements of height and weight in accordance with paragraph (B) of this rule, laboratory testing if medically indicated, in accordance with paragraphs (H) and (I) of this rule, a complete physical examination in accordance with paragraph (B) of this rule, and a dental screening in accordance with paragraph (J) of this rule.
(E) Vision Screening

(1) The provider shall perform a vision screening as part of each initial and periodic Healthchek (EPSDT) screening visit using the following criteria:

(a) Individuals ages birth to 3 years shall be screened by reviewing the individual’s medical history for risk factors and by performing an external (gross) observation and (internal) ophthalmoscopy.

(b) Individual’s ages 3 and older are required to be screened by:

(i) External (gross) observation and (internal) ophthalmoscopy;

(ii) Visual acuity test (e.g., Titmus, Snellen, Lea, or Tumbling E);

(iii) Ocular muscle balance test, administered at distance and near; and,

(iv) Stereopsis test (e.g., random dot E).

(2) When the vision screening indicates a potential visual problem or when a parent, teacher, professional, or responsible adult suspects that the individual has a vision problem, the provider shall, without delay, make a referral for the individual to a participating ophthalmologist or an optometrist for evaluation, diagnosis and/or treatment.

(F) Hearing Screening

(1) The provider shall perform a hearing screening during each initial and periodic Healthchek (EPSD) screening visit using the following criteria:

(a) Individuals ages 1–3 years shall be screened by:

(i) Reviewing the individual’s history for risk factors or symptoms indicative of hearing problems; and

(ii) Observing the child for, and questioning the parents about, physical behaviors or speech development, that may suggest a hearing impairment.

(b) Individual’s ages 3 and older shall be screened by:

(i) Using manually administered, individual pure-tone, air conduction equipment, if the provider has the equipment available; or

(ii) When pure-tone equipment is not available, providers are encouraged to refer children to another plan provider for a pure-tone test.

(2) When the hearing screening indicates a hearing impairment or a parent, teacher, professional, or other responsible adult reports that the child may have a hearing problem, the provider shall, without delay, make a referral for the child to a participating plan provider who specializes in the evaluation, diagnosis and treatment of hearing problems.
(G) Immunization Screening

(1) The provider shall perform an immunization screening as part of the basic examination component of each initial and periodic screening visit and shall include a history of past immunizations.

(2) If at the time of the screening, an immunization is needed, the provider shall provide the immunization or refer the individual for the appropriate immunization unless the immunization is medically contraindicated. If medically contraindicated, the immunization shall be rescheduled as appropriate.

(3) The provider shall use the plan-approved immunization guidelines based on the CDC Guidelines, the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

(H) Lead Toxicity Screening

(1) The Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) require the following lead screening:

(a) All children must receive a blood lead screening test at 12 months and 24 months of age.

(b) Children between the ages of 36 months and 72 months of age shall receive a blood lead screening test if they have not been previously screened for lead poisoning.

(c) A blood lead screening test shall be used when screening.

(i) The test methodology used for the required blood lead screening test shall have the sensitivity to detect blood lead levels of 10 micrograms per deciliter or lower.

(ii) The Erythrocyte Protoporphyrin test does not meet this standard, and is not acceptable as a blood lead screening test. The Erythrocyte Protoporphyrin test may be used to diagnose other conditions such as iron deficiency.

(d) Children of any age may be screened.

(I) Laboratory Tests

(1) Based on the individual’s medical and nutritional history, age, physical condition, ethnic background, and home environment, the primary healthcare provider shall determine and order the appropriate laboratory procedures.

(2) These laboratory procedures shall include, but are not limited to, the following:

(a) Blood Lead Screening Test: In accordance with paragraph (H) of this rule.

(b) Hemoglobin and/or Hematocrit: Anemia is a common condition reported during the Healthchek (EPSDT) screening visit. At a minimum, a hematocrit and/or hemoglobin is recommended on all premature and low birth weight infants during the first 6 months of life. If medical indications are noted in the physical examination, a test for anemia may be performed at any age. Such medical indications include a history of inadequate iron in the diet, a history of blood loss, family history of anemia, or pallor.

(c) Sickle Cell Test: It is recommended that a test for sickle cell and/or other hemoglobinopathies be performed at least once on all children of African-American, Greek, Italian, Arabian, Egyptian, Turkish, or Asiatic Indian descent. If it cannot be determined that a child has been tested previously, a test for the sickle cell or other hemoglobinopathies should be performed.
(d) **Pap Smears and Tests for Sexually Transmitted Infections**: Pap smears are recommended for all females (age 18 or older). Sexually active adolescents should be tested regardless of age. Individuals shall be informed about all tests performed, given results of each test and provided health education regarding sexually transmitted infections in accordance with paragraph (K) of this rule.

(e) **Tuberculin Test**:

(i) A tuberculin test shall be performed on all individuals who:

(a) Are suspected of having mycobacterial infection;

(b) Have a known history or exposure to active tuberculosis (TB);

(c) Are immigrants from high-prevalence areas of TB;

(d) Are from areas of high-endemic rates of TB; or

(e) Are members of families or social groups with an increased incidence of the disease.

(ii) If an individual does not meet at least one of the conditions listed in paragraph (I)(2)(e)(i) of this rule, TB testing is optional.

(f) Other laboratory screens as medically necessary.

(J) **Dental Screening**

(1) For children from birth through the age of 2 years, the provider shall perform a dental screening as part of the basic examination component of each initial and periodic screening visit, and shall include at a minimum:

(a) A screening of the growth and development of the dentition and adjacent dento-facial structure, and an oral inspection for dental caries shall be performed. Individuals shall be provided health education regarding early childhood caries prevention in accordance with paragraph (K) of this rule.

(b) When a dental screening and oral inspection indicate the need for further evaluation, the provider shall, without delay, make a referral to a plan dentist for evaluation, diagnosis and/or treatment.

(c) Diagnostic and preventive dental examinations shall be provided to individuals at ages and at frequencies in accordance with American Academy of Pediatrics recommendations for Preventive Pediatric Health Care. Providers are encouraged to refer children, beginning at age 2 to a plan dentist.

(2) For children ages 3 years through 20 years, the provider shall perform a dental screening during each initial and periodic screening visit, and shall include, at a minimum:

(a) Providers of the Healthchek (EPSDT) screening visits shall provide individuals ages 3 years and older with referrals to a plan dentist if the individual has not been seen by a dentist or dental hygienist under the direct supervision of a dentist during the last 6 months.

(b) Physicians are encouraged to emphasize the importance of preventive dental health care available under the Medicaid program. Providers should explain that cleanings, examinations and fluoride treatments are covered every 6 months. Dental sealants are covered for permanent first molars for children under age 9 and for permanent second molars for individuals under age 18.
(K) Health Education, Counseling, Anticipatory Guidance, and Risk Factor Reduction Interventions

(1) Health education, including counseling, anticipatory guidance and risk factor reduction intervention, is a required component of each Healthchek (EPSDT) screening visit. Health education should be designed to assist parents and individuals in understanding what to expect in terms of the individual's development and to provide information about the benefits of healthy lifestyles and practices, and disease prevention.

(2) Providers should encourage parents and individuals participating in the program to take advantage of screening services, dental services, vision services, and hearing services covered under Medicaid.

(3) Health education and counseling is part of each initial and periodic Healthchek (EPSDT) visit.

(L) Referrals

When a Healthchek (EPSDT) screening visit indicates the need for further evaluation of an individual's health, the provider shall, without delay, make a referral for evaluation, diagnosis and/or treatment. Evaluation, diagnosis and/or treatment may be provided at the time of the Healthchek (EPSDT) screening visit if the healthcare professional is qualified to provide the services.
Healthchek (EPSDT) Billing Guidelines

Participating providers will be reimbursed for all initial and periodic screening services. In order for the Healthchek examination to be properly captured and reimbursed, claims must be submitted on the HCFA 1500 form or by 837 electronic claims submission. Codes to identify Healthchek (well-child) visits are listed below.

(1) The following code set was in effect as of January 2010 and is subject to change. Please refer to the Ohio Administrative Code for the most current information.

- **Preventive Medicine** (ICD-9 CM Diagnosis codes)
  - V20.2  V70.0  V70.6
  - V20.31 V70.3  V70.8
  - V20.32 V70.5  V70.9

- **New Patient Service** (CPT 4 – E/M codes)
  - 99381  99383  99385
  - 99382  99384

- **Established Patient Service** (CPT 4 – E/M codes)
  - 99391  99393  99395
  - 99392  99394

(2) Providers of Healthchek (EPSDT) screening visits shall include the following information when billing, based on the date of service and type of claim submission.

(i) When billing electronically using the 837 professional claim transaction, use the EPSDT referral feature in the 2300 claim information loop to indicate that Healthchek (EPSDT) referral was made by placing a “Y” in the “Yes/No” condition or response code data element, and complete the condition indicator data element in the Healthchek (EPSDT) referral feature area.

(ii) When using a paper claim form, follow the instructions provided in Chapter 5101: 3-14-04 of the Administrative Code, paragraphs (A) (2) (a) (i) and (A) (2) (a) (ii) of this rule which require that item 24h on the paper claim form be completed.

**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 Ohio Department of Medicaid (MCD), formerly the Ohio Department of Job and Family Services (ODJFS) and Paramount Advantage will monitor the quality and frequency of screenings. Physician compliance with both the documentation, provision of these services and billing codes will be monitored.

There are 17 different age-specific well-visit forms on the Paramount website. Providers may print these forms and use them free of charge. Providers using electronic medical records (EMRs) should compare the forms to their EMR record to make sure all elements of a complete Healthchek exam are included in their forms.
Prenatal to Cradle (PTC) Program

Pregnancy Care Reward Program

- Promotes early and regular pregnancy care
- Pregnant Paramount Advantage moms can earn up to $100 to buy items to help care for their baby
  - Members earn a $25 gift card for each trimester they attend the recommended number of prenatal visits
  - Members also earn a $25 gift card for attending a postpartum appointment within 21-56 days after delivery
- To participate, members must register for Prenatal to Cradle (registration form is in the PTC brochure)
- To qualify, the Paramount Advantage member must be pregnant and enrolled in Paramount Advantage at the time of her appointment
- All appointments will be verified by provider-submitted claim reports

For more information call 888-296-0220.
Postpartum Home Health Care Program

Paramount Advantage members who are pregnant are considered to be “at risk” due to socioeconomic status. In order to positively impact the health status of these mothers and their newborns, the Paramount Advantage Postpartum Home Health Care Program was initiated in February 1994.

The purpose of the program is to provide two home health care visits to Paramount Advantage members who have delivered a baby. The visits provide the home health nurse the opportunity to assess the home situation and provide education to the mother regarding breast care, peri-episiotomy care, incision care (if Cesarean section or post tubal ligation), assessment/intervention for potential complications, and birth control alternatives.

Newborn education includes breast and/or bottle-feeding, cord and circumcision care, bathing, the importance of immunizations, dental care, holding and bonding, and testing for lead poisoning. Other educational opportunities include the dangers of shaking the baby, fall prevention, use of a car seat, signs and symptoms of postpartum depression, along with the signs and symptoms of illness for the baby.

In addition, the nurse has the occasion to assist with WIC referrals and setting up first follow-up visits for the mother and baby.

The collaboration of hospitals, home care agencies, managed care organization (MCO), and prenatal task force has improved the process by which more members are identified and given a better opportunity for service.

Home health postpartum visits provide the new mother with the opportunity to ask questions that have arisen since discharge and allow for early intervention by the healthcare system should problems be identified.
Neonatal Intensive Care Graduate Home Care Program

Paramount identified a need to help bridge the gap from the Neonatal Intensive Care Unit (NICU) to home, reduce length of stay in the NICU and decrease risk of readmission. Paramount developed the NICU Graduate Home Care Program to assure a safe transition from an intensive setting to home.

This program offers two initial home care nurse visits post-discharge for the high-risk babies cared for in the NICU. The discharge planner coordinates the discharge with the NICU staff, or in some cases the Primary Care Physician (PCP)/pediatrician, to obtain an order for the post-discharge visits. Additional visits may be requested and authorized, based on the needs of the baby.

The overall goals of the NICU Graduate Home Care Program are to:

- Reinforce hospital discharge instructions
- Provide a newborn assessment in the home
- Provide education on newborn care and feeding
- Identify a need for and provide information on community resources
- Assure that appointments are made and kept with the new PCP/pediatrician
- Educate on the importance of vaccinations to prevent disease
- Identify babies who could benefit from Paramount’s case management program
- Decrease hospital readmission rates by early identification of problems and timely intervention to preventing complications
- Identify infants who qualify for Synagis, the medication to help prevent respiratory syncytial virus (RSV)

The Neonatal Intensive Care Graduate Program has been favorably received by both families and physicians. Paramount welcomes the opportunity to continue offering this program and provide needed support to this fragile population.

How the Program Works Currently in Northwest Ohio

1. The NICU social worker/discharge planner initiates the process after obtaining agreement for participation from the parents.
2. A Home Health Certification and Plan of Care is sent to the physician within 7-10 days of the first visit for the physician to sign and return to Caring Home Health Services (CHHS).
3. Additional orders may be added by contacting Caring Services Visiting Nurses at 419-291-2273 or 800-534-2355.

As we move forward with the expansion throughout the State of Ohio, we will be working with various home care agencies to implement a similar program.
Transportation Assistance Program

Members have three choices when scheduling transportation assistance:

- Vehicle transportation
- Public bus transit
- Gas reimbursement

Transportation Scheduling

866-837-9817 or TTY call 800-750-0750
Monday – Friday, 8:30 a.m. – 5 p.m.

Vehicle transportation and gas reimbursements must be scheduled at least two business days before a Medicaid-covered appointment. Public bus transit must be scheduled at least seven business days before a Medicaid-covered appointment.

Urgent Sick Calls

If a medical provider must see an Advantage Member with less than two days’ notice, the member can call transportation scheduling to schedule an urgent sick call. The call center may contact the provider office to verify appointment urgency. The call center is allowed up to four hours to find an available driver. Based on the time of the request and availability of drivers, all urgent sick calls may not be guaranteed transportation.

Provider Questions or Concerns?

Call Paramount Advantage at 419-887-2550.
**Provider Data Change Form**

Please provide all information pertinent to changes you are requesting. Forward the completed form to: Provider Relations Department, Paramount, P.O. Box 928, Toledo, OH 43697 or fax to: Provider Relations Department at 419-887-2021 or 855-896-0854. Any questions, please call the Provider Relations Department at 419-887-2855.

| Today's Date: ________________________________ | Effective Date of Change: ____________________ |
| Provider ID #: ________________________________ | Required New Data: ________________________________ |
| Provider/Group Name: ____________________________ | NPI #: ____________________________ (PLEASE ATTACH A LIST OF ALL NPI NUMBERS YOUR PRACTICE USES) |
| Contact Person: ___________________ (PLEASE PRINT) | Title: ____________________________ (PLEASE PRINT) |
| Office Address: ____________________________ | |

**Indicate Type of Change Being Made**

| Change of Primary Practice/Business Address | Closed to New Patients |
| Change of Billing Address | Open to New Patients |
| Change/Addition of Secondary Location | Change in Office Hours |
| Change in Tax ID # (30-DAY NOTICE REQUIRED) | Termination (90-DAY NOTICE REQUIRED) |
| Change/Addition to On-Call Arrangements | IF ANY OF THE CHANGES REQUIRE MORE SPACE THAN LISTED BELOW, ATTACH A LIST OF YOUR CHANGES |

New Primary Address: ____________________________

*Old* Primary Address: ____________________________

New Billing Address: ____________________________

*Old* Billing Address: ____________________________

New Secondary Address: ____________________________

New Phone Number: (_____) _________________ Fax: (_____) _________________

New Tax ID #: __________________ (PLEASE ATTACH OR FAX NEW W-9)

New Office Hours: ____________________________

Termination – Effective Date: ____________________________

New On-Call Arrangements: ____________________________

Provider Rep Signature: ____________________________ [FOR INTERNAL USE ONLY]

*Please add practice rosters or other lists as necessary.*
Member Termination Procedure

Paramount allows for termination of a member by the physician. If extenuating issues are present, this may include extensive compliance issues according to office policy. Talk with your Provider Relations Representative if you have questions or concerns. The following procedure must be followed.

1. The office must send a certified letter to the member notifying the member of the termination. A copy of the letter must be submitted to the Member Services Department either by fax or mail.
   Fax: 419-887-2047
   Mail: P.O. Box 928
   Toledo, OH 43697-0928
   Attn: Member Services

2. The Member Services Department will then notify the member to choose a different primary care physician.

3. The current primary care physician must provide emergency coverage for the member for a period of 30 days following notification. After 30 days, if the member has not selected a new primary care physician, one is assigned by Member Services.

Please note:
If termination is being considered due to problems with keeping appointments or compliance with a treatment plan, please consider contacting Paramount Advantage Case Management to have a case manager attempt to work with your member and avoid the need for termination.

Contact: Julie Hoskins, RN, CCM, Manager
Call 419-887-2220
Fax 419-887-2028
Attention: Julie Hoskins
Financial Responsibility/Medicaid Notification

When notifying patients of financial responsibility, the State of Ohio Medicaid program requires a form to include the following five points:

- Must be in writing
- Must indicate specific date of service
- Must note the specific item or service
- Must note that the item or service is NOT covered
- Must indicate the amount for which the patient is responsible

A sample Notification of Financial Responsibility Form may be found below:

Medicaid Financial Responsibility Notification (Sample)

Provider Name: __________________________

Ohio Model Medicaid Addendum Language

Provider may bill the member when Paramount Advantage has denied prior authorization or denied a referral, or the service is not covered. The following conditions must be met:

1. The member (your patient) must be notified that the service to be rendered is the member’s personal financial liability in advance of service delivery.
2. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients or for all services is not sufficient for this purpose.

Provider Section
List specific service/product to be rendered: ____________________________________________

Date of Service: __________________________
List amount member will be responsible for: ____________________________________________

Member Section

I understand that the service to be provided has not been approved by Paramount Advantage OR is not a covered service through MCD (Ohio Department of Medicaid). I clearly understand that I will be billed by the provider for this service and that I am financially liable.

The provider may not submit a bill to Paramount Advantage.

Member Name: ____________________________
Member Signature: __________________________ Date: __________________________
Member Marketing Materials

Paramount Advantage (MCP) is responsible for ensuring that all marketing and member materials are prior approved before being used or shared with members or potential members. (Pursuant to OAC rules 5101:3-36-08 and 5101:3-26-08.2).

MCP marketing and member materials must not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or the Ohio Department of Medicaid (MCD).

MCP marketing materials cannot contain any assertion or statement (whether written or oral) that the MCP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or State government or similar entity.

Prior to sending any marketing materials to members, please provide Paramount Advantage the opportunity to review them. This will ensure compliance with regulatory requirements.
**Benefit Fax Inquiry**

To: Paramount – Provider Inquiry  
Fax: 419-887-2014  866-768-5372 toll-free FAX

From: ____________________________  Phone: ____________________________  Fax: _________________
Provider Name: ____________________  Paramount Provider #: ____________________

**Regarding Benefit Verification**

Please include applicable HCPCS code(s) for DME, orthotics, prosthetics, and pharmacy.

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<tr>
<th>Member ID#</th>
<th>Services to be Provided</th>
<th>Date of Service</th>
<th>Response from Paramount</th>
<th>Services Require an Authorization (y/n)</th>
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Claims Fax Inquiry
To: Paramount – Provider Inquiry
Fax: 419-887-2014  866-768-5372 toll-free FAX

From: 
Phone: 
Fax:
Provider Name: 
Paramount Provider #: 

Regarding Claim Status Request

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PRESCRIPTION DRUG COVERAGE
SECTION 3.0
Prescription Drug Coverage

Prescription drug coverage is provided through Paramount Advantage (MCP/Medicaid Managed Care Plan) in cooperation with Express Scripts, Inc. Members may call Paramount Member Services or access our website to find participating pharmacies. The Paramount Advantage Prescription Drug plan covers preferred brand drugs, many generic drugs, certain over-the-counter medications, and some medical supplies when a prescription is provided to the member. The “Paramount Advantage (Medicaid) Preferred Drug List” is available through our website. Visit paramounthealthcare.com. Click on Providers > Prescription > Preferred Drug Lists for the most current list.

Prior Authorization

Prior authorization will be required for some prescription drugs such as non-formulary requests, clinical prior authorizations, and step therapy. Visit our website at: paramounthealthcare.com. Click on Providers > Prescription > Prior Authorization & Step Therapy Policy for more information. Our Pharmacy & Therapeutics Committee approved prior authorization criteria and respective request forms are also found here.

- Prescription drugs on the prior authorization list will need to be reviewed and authorized through Paramount. Call us at 419-887-2520, option 2 (or toll free at 800-891-2520 option 2).

Specialty Drugs and Specialty Network

Specialty drugs are prescription drugs which treat complex conditions such as multiple sclerosis, cancer, hepatitis or rheumatoid arthritis. They can be self-administered and often require special handling or monitoring. Most of these drugs also require prior authorization.

These drugs are available through a limited pharmacy network called the Specialty Network. To see a list of drugs that are designated as specialty drugs and/or locate a specialty pharmacy in the Paramount network, visit our website by clicking Providers > Prescriptions > Specialty Drug Program.

Infusables/Injectables

Injectable drugs can be covered under medical or pharmacy benefits. Most self-injections will be covered under the prescription benefit. Injectables are often limited to our specialty network and require prior authorization. Refer to the prior authorization and specialty drug program information available at our website. Click Providers > Prescriptions > Specialty Drug Program [or] Prior Authorization and Step Therapy Policy.

- Call 419-887-2520, option 2 (or toll free at 800-891-2520 option 2) for assistance with injectable coverage.

Limited Medical Supplies

Certain medical supplies are covered for Paramount Advantage members through the prescription drug benefit, including diabetic supplies (glucometers, test strips, syringes, needles, alcohol wipes), spacers for inhalers or peak flow meters, and condoms.
Prescription Drug Coverage (continued)

**OTC (Over the Counter) Drug Coverage**

Limited coverage of OTC medications is available for Paramount Advantage members. In order for these medications to be covered, a prescription is needed for the pharmacy to bill Paramount. Examples of covered OTC drugs include:

- Allergy medicines (Cetirizine, Diphenhydramine, Loratidine, Oxymetazolone, etc.)
- Contraceptives (Male & female condoms)
- Cough & Cold (Delsym, Mucinex, Robitussin, Saline nasal sprays, etc.)
- Diabetic Supplies (Alcohol wipes, glucometers and supplies, Lancets, etc.)
- First Aid (Bacitracin, Triple antibiotic)
- Pain Medications (Acetaminophen, Aspirin, Ibuprofen, Naproxen, etc.)
- Skin Products (Benzoyl Peroxide, Hydrocortisone, Lamisil)
- Smoking Cessation (Nicotine replacement products including gum, patches, lozenges)
- Stomach & Gastrointestinal (Bisacodyl, Docusate, Fiber supplements, Loperamide, Maalox, Magnesium Citrate, Milk of Magnesia, Miralax, Omeprazole, Pink Bismuth, Prevacid, Psyllium, Simethicone, Zegerit OTC, etc.)
- Vaginal Products (Miconazole, Gyne-Lotrimin, Vagistat, etc.)
- Vitamins/Minerals (Calcium, Folic Acid, Iron, Magnesium, Multivitamins, Niacin, etc.)
- Other Items (Debrox, Nix, Pedialyte, Rid, etc.)
PRIOR AUTHORIZATIONS
SECTION 4.0
Out-of-Plan Referral Requests

Out-of-plan referrals are required for payment of all services performed outside of Paramount’s network. Paramount’s goals for facilitating an out-of-plan referral is to obtain a determination within two days from receipt of the medical documentation. In order to expedite this process, Paramount has developed specific guidelines to follow when requesting out-of-plan referrals. Providers will receive a return fax with the authorization number within five working days of receipt of the request. Referral confirmation letters will be mailed to the facility of service and member for all approved requests.

Guidelines

Elective (Non-Urgent) Out-of-Plan Referrals
Elective referrals to a non-participating provider or healthcare facility must be approved in advance of service delivery by Paramount. Decisions for payment of non-urgent out-of-plan services will be made within two working days of obtaining all necessary information.

Urgent Out-of-Plan Referrals
Urgent care treatment in an out-of-plan provider office or facility setting requires prior authorization for payment of services. Determinations are expected within 24 hours in urgent situations.

Urgent care treatment in an urgent care facility does not require prior authorization for payment of services.

Emergent Referral
Emergency care outside of the provider network does not require prior authorization.

In order to expedite your request for an out-of-plan referral, a new form has been developed as an out-of-plan referral worksheet (see next page). Please make copies of this form and use it when requesting an out-of-plan referral. Complete the entire form and send or fax it with the appropriate medical documentation including:

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing
- Reason for out-of-plan referral
- Referring physician’s expectation of the out-of-plan referral
- Consult or treatment documentation from the in-plan or out-of-plan specialist
Out-of-Plan Referral Worksheet

Phone Number 419-887-2520
Fax Number 419-887-2028
Attention: Out-of-Plan Coordinator

Date of Request: __________________________

Member Name: __________________________________________
Member ID #: __________________________________________

Referring Physician: ______________________________________
Contact Person: __________________________________________

Phone Number: ____________________, Fax Number: ___________

Diagnosis: ____________________________________________ ICD-9 Code: ___________
Procedure Type: _____________________________ CPT Code: ___________

Date of Appointment: _______________________________

Name of Facility: _______________________________________
Name of Specialist and Specialty: __________________________
Address: ______________________________________________
City/State/Zip Code: ____________________________________
Telephone Number: ____________________________________

Please send the following information

• Brief medical/clinical history
• Current signs and symptoms
• Results of any pertinent diagnostic testing
• Reason for out-of-plan referral
• Referring physician’s expectation of the out-of-plan referral
• Consult or treatment documentation from in-plan or out-of-plan specialist

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Imaging Prior Authorization Questions and Answers

What You Need to Know

What imaging scans require prior authorization?
• Elective MRI, CT Scans, CTA Coronary Arteries, and Nuclear Cardiology (A complete listing is also available at paramounthealthcare.com)

What product lines are affected by the prior authorization requirement?
• HMO, Point-of-Service (Flex), Paramount Elite (Medicare), and Paramount Advantage (Medicaid)

Who should submit the request for prior authorization?
• Paramount will accept requests from the ordering physician or the facility performing the imaging procedure.

How do I submit a prior authorization request?
• The quickest way to get approval is submitting through Clear Coverage™.
• Due to the required documentation, requests and supporting medical documentation can also be submitted via fax to 419-887-2028 or 866-214-2024. (Fax form is included and also available at paramounthealthcare.com.)

What medical documentation needs to be submitted with the fax request?
• Medical/clinical history
• Current signs and symptoms
• Results of any other pertinent diagnostic testing
• Consult or other treatment documentation supporting the rationale for procedure

Remember: Authorizations will be CPT and ICD-9 specific based on your request. Claims will be paid only if the codes billed are the same as those requested. If you find that the services rendered are different from the services approved and the claim will have different CPT and/or ICD-9 codes, please fax the correction to the Utilization/Case Management Department so that the authorization can be changed. This will result in your claims being paid on first pass, instead of being denied and requiring an appeal.

How long will it take to get the request approved/denied?
• Paramount has dedicated Utilization/Case Management staff supporting this process. Providers will receive a return fax with the authorization number within five working days of receipt of the request. Referral confirmation letters will be mailed to the facility of service and member for all approved requests. In the event of a denial, requesting providers will receive a telephone call and a denial letter that contains rationale and appeal rights.

What if the prior authorization request is denied?
• Ohio Revised Code 1751.82 gives the provider the right to request reconsideration on behalf of the patient.

What about patients who need their test “stat” or after hours?
• In the event that there is a true emergency and there is no time to request prior authorization, the provider should ALWAYS address the needs of the patient first and deal with authorization issues the next business day. Emergency services are defined as being required as the result of an emergency medical condition. Paramount will review these requests against medical-necessity criteria.
Imaging Prior Authorization Questions and Answers (continued)

What is an emergency medical condition?
• A condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
  1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy
  2. Serious impairment to bodily functions
  3. Serious dysfunction of any bodily organ or part

Can authorizations be viewed on the web in Provider DIRECT?
• Authorizations will be entered as an overnight process. Approved authorizations will be available for viewing in Provider DIRECT.
• **Note:** The denied authorizations WILL NOT appear on Provider DIRECT

Only approvals will appear on Provider DIRECT. Approved authorizations can only be viewed by the provider who requested the prior authorization.

How long will the authorization be valid?
• Generally for a 3-month time period. Subsequent procedures that are part of a documented ongoing treatment plan will have the time frame extended for a 6- to 12-month time frame. Keep in mind that individual member benefit designs could change during that time period.

Do all locations require a prior authorization?
• Procedures billed with location 21 (inpatient) or location 23 (emergency room) do not require prior authorization.

Can an authorization be obtained for a CT or MRI and then be billed from the physician’s office?
• No. Authorizations will be issued only to approved, participating imaging providers. Any MRI or CT in the physician’s office must meet Paramount’s credentialing criteria and be approved for these services. You may call our Credentialing Department at 419-887-2844 for a copy of the criteria.
OUTPATIENT IMAGING PRIOR AUTHORIZATION FAX REQUEST FORM

PLEASE FAX THIS FORM AND THE FOLLOWING INFO TO PARAMOUNT’S U/CM DEPT 419-887-2028

DATE OF REQUEST: ______________________ DATE OF PROCEDURE: _________________________

MEMBER NAME:____________________________________________ DOB: _________________________

PARAMOUNT MEMBER ID NUMBER: ________________________________________________________

ORDERING PHYSICIAN: _________________________ ORDERING PHYSICIAN PROVIDER ID:________

CONTACT NAME:_____________________ PHONE:__________________ FAX: __________________________

FACILITY PERFORMING PROCEDURE: __________________________________________________________

PLEASE COMPLETE STEPS 1 - 4

1. BODY PART TO BE TESTED: _______________________________________________________________

2. PLEASE CHECK TEST TO BE PERFORMED:

   □ MRI SCAN with contrast CPT:_______________________________________________
   □ MRI SCAN without contrast CPT:_______________________________________________
   □ MRA SCAN with contrast CPT:_______________________________________________
   □ MRA SCAN without contrast CPT:_______________________________________________
   □ CT SCAN with contrast CPT:_______________________________________________
   □ CT SCAN without contrast CPT:_______________________________________________
   □ CTA Coronary arteries CPT:_______________________________________________
   □ NUCLEAR CARDIOLOGY (ENTER TEST TYPE)_______________________________________________

3. DIAGNOSIS: __________________________________________ ICD-9:____________________________

4. MEDICAL/CLINICAL HISTORY:

   Current signs and symptoms:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

   Results of any other pertinent diagnostic testing:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

   Consult or other treatment documentation supporting rationale for procedure:
   ___________________________________________________________________________________
   ___________________________________________________________________________________

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Rev 10/2012
Hospital Facility Prior Authorization Requirements

Paramount’s Utilization Management Program uses the most current edition of the McKesson InterQual® Criteria (Acute Pediatric; Acute Adult; Behavioral Health Chemical Dependency & Dual Diagnosis (Adult & Adolescent); Behavioral Health Psychiatry (Adult, Child, Adolescent, Geriatric); Residential and Community-Based Treatment (Adult, Adolescent & Child), Molecular Diagnostics (MdX) and Imaging) as the basis for determining medical necessity.

InterQual® criteria are applied in reviewing the appropriateness of:

- inpatient acute care admissions,
- inpatient acute rehabilitation admissions,
- skilled nursing facility admissions,
- mental health and chemical dependency partial hospitalization,
- intensive outpatient services,
- home health care services,
- genetic testing and
- elective, outpatient imaging studies

Guidelines

Observation Stays
Paramount does not need to be notified of an observation stay if the stay is less than 48 hours. Typically, an observation stay over 48 hours should be converted to inpatient and must meet admission criteria for payment. Paramount must be notified when observation stays are over 48 hours or when they are converted to an inpatient status. Fax is the preferred method of communication (866-214-2024), but phone calls are accepted (800-891-2520).

Inpatient Admissions
Paramount requires notification of an inpatient stay by the next business day following the admission. This includes elective admissions. Please send the admitting face sheet with the patient’s demographic information along with a clinical review. Paramount will respond with an authorization number and length of stay within one business day. Concurrent review will be required on the expiration of the Paramount-assigned length of stay. Concurrent review clinical information should be faxed or called promptly on the expiration date (weekend & holiday expiration dates should be faxed/called the following business day). Please include contact information on the fax (name of facility UM reviewer, fax and telephone number). Fax is the preferred method of communication (866-214-2024), but phone calls are accepted (800-891-2520).


Note: Paramount attempts post-discharge telephone calls to all of our members to ensure appropriate transition to the home setting. This will include confirmation that discharge plans are being followed, prescriptions are filled and follow up appointments are made.

Home Health Care
Home Health care services require prior authorization to be done by the Home Health care provider. Prior authorization forms are available on Paramount’s website. Reviews are conducted prospectively and concurrently.
Web-Based Prior Authorization Tool – McKesson’s Clear Coverage™

For CT, CTA of Coronary Arteries, MRI, MRA, and Nuclear Cardiology

As a result of office feedback about the prior authorization process, Paramount implemented a web-based prior authorization submission tool (McKesson’s Clear Coverage). This new tool automates the authorization request process for CT, CTA of coronary arteries, MRI, MRA, and nuclear cardiology and will provide instant approval for provider requests if criteria are met.

The tool utilizes InterQual® criteria sets for medical-necessity determinations, thus medical-necessity requirements will NOT change.

This tool is for those providers who currently send authorization requests directly to Paramount.

How does this tool work?
Q. What can I expect if imaging criteria are met?
A. An authorization number/confirmation of approval is given immediately.

Q. What can I expect if medical-necessity criteria are not met?
A. If medical-necessity criteria are not supported for the imaging study, you can expect the following:
   • The request will “pend” for review by one of Paramount’s Associate Medical Directors.
   • Upon review, the individual member’s medical condition(s) and past treatment, will be taken into account in the authorization decision.
   • A determination will be viewable within two business days in the McKesson Clear Coverage tool.

Login Request for Clear Coverage

Only sign up for the web-based tool if you currently send authorization requests directly to Paramount. What will I need on my computer prior to using the web-based authorization submission tool?
• Adobe Reader
• Adobe Flash (version 10 or higher)
• Internet Explorer (version 8 or higher)
• Screen resolution of at least 1024 x 768

How do I request my login?
1. Go to paramounthealthcare.com/clearcoverage
2. Complete the “Login Request” form and click the submit button.
3. Allow seven working days for your request to be processed.
4. You will be sent your login by email, along with brief instructions about how to request authorizations and use the tool.
5. Technical questions can be emailed to phchelpdesk@promedica.org. If you have questions related to how to use the tool, call Provider Relations at 419-887-2535 or 800-891-2542.
CASE MANAGEMENT
SECTION 5.0

PARAMOUNT ADVANTAGE
Affiliate of ProMedica
Case Management Fact Sheet

What is Case Management?

- It is a program to identify and manage members at high risk for complex, costly or long-term healthcare needs.
- Case managers are Registered Nurses or Social Workers.
- Case managers work 1:1 with members and their PCPs to ensure that medically appropriate services are provided in a supportive cost-effective environment.
- Case managers follow members through the continuum of care from home to office, home health care, in-patient hospitalizations, rehabilitation, SNF, and home again.
- Assist with utilization of participating providers.

Case Management Goals

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

Physician’s Role

- PCP is responsible for coordinating all aspects of the member’s medical care; the case manager assists the PCP with the process.

Identify...

- Patients who are at a high risk for frequent hospitalizations
- Inappropriate utilization of the ER
- High-risk/complicated pregnancies
- Noncompliance or missed appointments
- Need for specialized care
- Potential transplant cases
- Oncology patients with complications
- Medically unstable or complex members
- Members with special healthcare needs
- Members with drug-seeking behaviors
- Members with behavioral health needs

It is the expectation of MCD, CMS and NCQA that we work closely with the PCP to develop and modify the member’s care treatment plan.

How to Make a Case Management Referral

To request an assessment for case management (HMO, Advantage and PPO)
Contact: Julie Hoskins, RN, CCM, Manager
Call 419-887-2220
Fax 419-887-2028
Attention: Julie Hoskins

To request an assessment for case management (Elite, Behavioral Health)
Contact: Debra Woody, MSN, RN, CCM
Call 419-887-2255
Fax 419-887-2028
Attention: Deb Woody
High Risk Care Management Accountable Point of Contact

Effective 6-27-12 the Ohio Department of Medicaid (MCD) requires that all Paramount Advantage members enrolled in High Risk Case Management must have a Paramount case manager function as an accountable point of contact (OAC 5101:3-26-03.1(A)(8)). The case manager is required by contract with MCD to have a face-to-face encounter with each member in high risk case management every quarter. Approximately 1% of our Advantage membership is placed in high risk case management.

In order to comply with this mandate, the case manager may visit members in your office at the time of their appointments. In all cases, the member will have advance knowledge and will be in agreement. We will also advise your staff of our planned visit.

The goal of our visit is to collaborate with the member, physician and staff, establish a relationship with the member, and create and update the care plan in conjunction with the member and physician.

Paramount appreciates your cooperation with this requirement and looks forward to building a relationship with you and your staff to better serve our members. If you have any questions, please contact Julie Hoskins, Advantage Case Management Manager at 419-887-2220.
DISEASE MANAGEMENT
SECTION 6.0

PARAMOUNT
ADVANTAGE
Affiliate of ProMedica
Changing Our Members’ Lives .... One Life at a Time

The value of condition management adds up to:

✓ Quality of Care
✓ Satisfied Members
✓ Reduced Medical Costs
✓ Best Possible Quality of Life
✓ Empowered Members
Your condition management team is made up of health care professionals dedicated to improving the health and quality of life for our members with chronic disease(s). The team includes:

- Physician advisors
- Pharmacy directors
- Certified diabetes educator
- Registered nurses
- Certified asthma educator
- Cardiopulmonary specialist / exercise physiologist

The team uses a holistic health approach, assessing physical, psychosocial, behavioral health, nutritional, environmental, and lifestyle issues. The goal is to promote wellness that encompasses the entire person, not just the chronic condition(s).

**Overall goals**

- Help members manage their condition(s) with personalized, caring and expert support, with a focus on education and strategies for:
  - Writing individual condition-specific action plans
  - Gaining knowledge and understanding of personal blood pressure readings, laboratory results and goals
  - Learning how to reach personal goals and follow individual treatment plans
  - Identifying triggers or things that cause symptoms and how to avoid them
  - Decreasing the number of missed work and/or school days
  - Smoking cessation plans
  - Adopting proper diet and exercise habits
- Increase the use of appropriate medications
- Improve medication and treatment plan adherence
- Increase the number of members receiving flu and pneumonia vaccinations
- Reduce use of the emergency room
- Decrease hospitalizations
- Lower unnecessary health care costs
- Prevent or delay disease problems and complications

**How It Works**

Members are identified through a sophisticated software application and classified into risk categories every month. All identified members receive some type of intervention. Those at greatest risk receive higher-touch interventions.

Major components in every disease management program are:

- Comprehensive health coaching calls to evaluate, assess and follow-up with those members at higher risk
- Case management evaluation and services for those members at the highest risk and/or during an acute illness

Pharmacy services, educational mailings, disease specific newsletters and community forums are also integrated into our disease management programs and activities. Web-based interactive tools and online support are also available.


**Paramount offers the following condition management programs:**

**Asthma Program Promotes:**
- Asthma education classes
- Use of daily asthma medication to prevent flare-ups
- Sharing personal Asthma Action Plan with families, employers, teachers, coaches

**Includes automatic health coaching for members:**
- Not on preventive asthma medication
- Who’ve gone to the emergency room for asthma

**Includes automatic case management services for members with:**
- Two or more asthma emergency room visits
- One or more hospitalizations for asthma

**Chronic Kidney Disease (CKD) Program Promotes:**
- Visits to a kidney specialist (nephrologist)
- Formal dietary education
- Blood pressure and cholesterol control
- Control of A1c and blood sugars for members with diabetes

**Includes automatic health coaching for all members with:**
- CKD Stages 3 and 4

**Includes automatic case management services for all members with:**
- CKD Stage 5 or End-Stage Renal Disease

**Congestive Heart Failure (CHF) Program Promotes:**
- Written CHF Action Plans
- Control of blood pressure, cholesterol, diabetes and weight
- Daily weights
- Formal dietary education, as appropriate
- Visits to a heart specialist (cardiologist) as appropriate

**Includes automatic health coaching/case management services for all members identified for the program.**

The CHF program also provides home care and monitoring to eligible members.

**Chronic Obstructive Pulmonary Disease (COPD) Program Promotes:**
- Pulmonary rehabilitation services, smoking cessation, COPD action plan

**Includes automatic health coaching for members with:**
- One or two COPD/COPD-related hospital admissions and/or emergency room visits

**Includes automatic case management services for members with:**
- Lung cancer
- More than three COPD/COPD-related hospital admissions and/or emergency room visits

**The COPD Management Program also provides:**
- In-home biometric monitoring through the COPD Health Buddy™ system
  - Information is sent daily over a phone line to trained staff
  - Phone calls from Health Buddy™ nurses

**Chronic Conditions and Depression Program Promotes:**
Members receive interventions described in the Depression Management Program and receive additional health coaching calls that include:
- Special periodic assessments to find out how well their depression is being managed
- Encouragement to discuss possible depression treatment plan changes with their physician, as appropriate

**High Risk Depression Program Promotes:**
- Visits to behavioral health providers for at risk members
- Prompt and ongoing follow-up doctor visits after being started on medication for depression
- Adherence to antidepressant medication
- Managing coexisting chronic medical conditions

**Includes automatic health coaching for members with:**
- Chronic medical conditions and depression

**Includes automatic case management services for members:**
- Who’ve had an emergency room visit for depression
- Who’ve attempted suicide
Diabetes Program Promotes:
- Diabetes education classes
- Visits to an endocrinologist (diabetes specialist)
- Recommended yearly diabetes testing
- Blood sugar, A1c, cholesterol, and blood pressure control

Includes Automatic Health Coaching for members:
- Missing recommended services
- With a diabetes emergency room visit
- With chronic wounds
- Whose A1c or cholesterol levels are not at goal

Includes Automatic Case Management Services for members with:
- A hospitalization for diabetes
- Two or more diabetes emergency room visits
- An amputation
- Skin ulcers

Migraine Headache Program Promotes:
- Visits to a headache specialist or neurologist
- Keeping an individual headache diary
- Medications to prevent migraine headaches from occurring

Includes Automatic Health Coaching for members:
- With migraine emergency room visits or hospital admissions
- Who’ve been on narcotic pain medications for 90 days or longer

Post Cardiac Event Program Promotes:
- Cardiac rehabilitation services
- Blood pressure and cholesterol control
- Recommended annual screenings

Includes Automatic Health Coaching/Case Management Services for ALL members identified for the program including calls to members:
- With cardiac related emergency room visits
- With cardiac related hospitalizations
- Missing recommended testing or medications
- Whose cholesterol levels are not at goal

Changing Our Members’ Lives .... One Life at a Time

The value of condition management adds up to:
- Quality of Care
- Satisfied Members
- Reduced Medical Costs
- Best Possible Quality of Life
- Empowered Members

1901 Indian Wood Circle
Maumee, Ohio 43537
419-887-2500
800-462-3589
www.paramounthealthcare.com
Clinical Practice Guidelines

The Clinical Guidelines for Physicians can be viewed and printed by physicians and physician offices from the Paramount website. These guidelines are evidence-based and intended for use as a guide in caring for Paramount members.

The Medical Advisory Council reviews and approves each guideline annually. The guidelines are adopted from various nationally recognized sources such as the American Diabetes Association; the American Academy of Family Practice; the American Academy of Pediatrics; the National Heart, Lung and Blood Institute; and the Agency for Healthcare Research and Quality. The guidelines will not cover every clinical situation and are not intended to replace clinical judgment.

You may locate the clinical guidelines at:
paramounthealthcare.com
Home > Providers > Publications and Resources > Clinical Practice Guidelines
as demonstrated by the screen copy below:

Should you have questions or require additional information, contact Paramount at:
phcquality@promedica.org.
BEHAVIORAL HEALTH SERVICES
SECTION 7.0
Behavioral Health Services for Paramount Advantage

(Mental Health and Chemical Dependency, Including Admissions for Detoxification)

Hospital Inpatient and Observation Admissions

A. Paramount reviews all hospital admissions for appropriateness and medical necessity.
   - Elective admissions are reviewed before the member is admitted to the hospital.
   - Urgent and emergency admissions are reviewed no later than the first business day after the admission occurs.
   - Generally, the hospital precertifies or certifies the inpatient admission. The physician’s office may also precertify an admission.
   - The review process is performed by telephone or by telefax with the Utilization Review Department at each hospital, or by Paramount on-site Behavioral Health U/CM Coordinators at larger-volume hospitals.
   - Exception: Services at an institution for mental disease (IMD, freestanding public or private psychiatric facility) are not a covered benefit for Paramount Advantage members between 22-64 years of age. Paramount is not responsible for facility or professional charges.
   - Exception: Services at an Institution for Mental Disease (IMD; freestanding public or private psychiatric facility) are a covered benefit for Paramount Advantage members 21 years of age or younger or 65 years of age and over. Paramount is responsible for professional charges. ODMH or ODADAS pays for the facility charges.

B. Pre-established medical necessity/appropriateness criteria are utilized to assure consistency in the certification process.
   - InterQual® Behavioral Health Criteria Sets are the basis for all determinations of medical necessity; these include child, adolescent, adult and geriatric psychiatry; adult chemical dependency; and dual diagnosis.

C. If an admission is approved, the Behavioral Health U/CM Coordinator assigns a length of stay, based upon diagnosis, presenting signs and symptoms, investment in treatment, support system, and/or other factors as delineated in InterQual criteria.
   - The admission is re-reviewed at appropriate intervals until the member’s discharge, or until the member no longer meets inpatient or observation criteria. The Behavioral Health U/CM Coordinator will identify the next expected review date.
   - Authorization of the admission includes all physician and ancillary services rendered during the inpatient or observation stay.
   - Excluded are those services that are not a covered benefit, such as convenience items.

D. Retrospective Review

Retrospective chart review is performed after the patient is discharged from the facility.
   - This type of review is necessary when Paramount Advantage/the Behavioral Health team is not informed of the member’s admission while he or she is an inpatient (when the member does not present correct insurance information at time of admission, for example), or when the member has been admitted and discharged during a time period when the Paramount reviewer was not working, such as on a weekend or holiday.

E. Not Covered
   - Behavioral Health U/CM Coordinators may exercise professional judgment for approvals when/if criteria are not met. Only the medical (MD) or clinical (PhD) director may deny for lack of medical necessity. Discharge planning is initiated to plan for continuing care after discharge.
Outpatient Services

A. The Behavioral Health Coordinator facilitates, and coordinates as required, the appropriate use of the benefits of and referrals to the publicly funded community behavioral health system, including community mental health centers (CMHCs) and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified Medicaid providers.

- Advantage members may self-refer to these agencies.
- In the event that services are not available from the community behavioral health system, or not available in a timely manner, or the member does not choose to use the community system, the plan is required to make arrangements for services outside this community network and must maintain an Advantage provider panel.
- Advantage members may self-refer to participating Advantage providers; no prior authorization is required.
- Paramount Advantage is financially responsible for long-acting injectable second generation antipsychotic drugs (e.g., Risperdal, Invega, Zyprexa) covered by Medicaid and administered by an ODMH CMHC. Although prior authorization based on medical necessity is not required, the provider must notify the Behavior Health team to assure payment.

B. Not Covered by Paramount Advantage

- Outpatient detoxification
- Methadone maintenance
- Substance abuse intensive outpatient programs (IOP)
- Partial hospitalization (mental health)
- Marriage counseling

Member Liability

A. The member has no liability (i.e., may not be billed) when a contracted/participating Advantage provider provides a covered service that requires prior authorization (for example, hospital admission), but for which the provider has not obtained required authorization.

B. The member is responsible (i.e., may be billed) for payment of non-covered services, including:

- All/any copays and coinsurance
- Non-covered services received, such as policy/contract exclusions
- Court-ordered testing or court-ordered treatment that is not medically necessary, or that is a non-covered service
- Employer-mandated testing or treatment that is not medically necessary, or that is a non-covered service
- Testing and treatment for learning disabilities and mental retardation
- Marriage or sexual counseling, hypnosis, biofeedback
- Treatment for non-acute conditions; conditions that are not treatable
- Services received after benefit is exhausted

A signed waiver meeting state guidelines must be obtained to bill an Advantage member.
Paramount Advantage

Paramount Advantage (Medicaid managed care product) mental health/substance abuse services are co-managed by Paramount's Behavioral Health team, the Ohio Department of Mental Health (ODMH), community mental health centers (CMHCs), and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified agencies.

- The state (MCD) intends that, in most cases, ambulatory services are provided by the community mental health centers and ODADAS agencies, and Advantage members may self-refer to these agencies.

- However, in the event that services are not available, not available in a timely manner, or if the member chooses not to use the community network, the plan is required to make arrangements for services outside this community network and must maintain an Advantage provider panel.

  - The plan is responsible for the provision of inpatient mental health/substance abuse services within its network.

Who to Call at Paramount

<table>
<thead>
<tr>
<th>Department</th>
<th>Type of Request</th>
<th>Telephone #/Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Management</td>
<td>Provider Requests:</td>
<td>419-887-2520, option #4, or 800-891-2520, option #4</td>
</tr>
<tr>
<td></td>
<td>- Prior authorization when required</td>
<td>Fax: 419-887-2028 / 866-214-2024</td>
</tr>
<tr>
<td></td>
<td>- Case/care management</td>
<td></td>
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<tr>
<td></td>
<td>- BH out-of-plan requests</td>
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<tr>
<td></td>
<td>- General clinical inquiries</td>
<td></td>
</tr>
<tr>
<td>Provider Inquiry</td>
<td>Provider Requests:</td>
<td>419-887-2564</td>
</tr>
<tr>
<td></td>
<td>Verification of benefits and claims payment issues</td>
<td>888-891-2564</td>
</tr>
<tr>
<td>Member Services</td>
<td>Member Requests:</td>
<td>419-887-2525 or 800-462-3589</td>
</tr>
<tr>
<td></td>
<td>All member inquiries and requests</td>
<td></td>
</tr>
</tbody>
</table>
A statewide initiative focused on coordinating mental and physical health care and boosting the overall health of Ohio’s Medicaid enrollees with **serious and persistent mental illness (SPMI)** and **serious emotional disturbance (SED)** was announced October 15, 2012. The Ohio Department of Mental Health (ODMH), in conjunction with the Office of Medical Assistance (Ohio Medicaid) will implement a new Medicaid benefit - called a Health Home – in five Ohio counties, including **Adams, Butler, Lawrence, Lucas, and Scioto**.

### An Overview of Medicaid HEALTH HOMES

**What is a Health Home?**

A Health Home is not a building; it is a coordinated, person-centered system of care. An individual who is eligible for Health Home services can obtain comprehensive medical, mental health and drug and/or alcohol addiction treatment, and social services that are coordinated by a team of healthcare professionals.

**Who will provide Health Home services?**

Community behavioral health providers who meet state-defined requirements, including integration of primary and behavioral healthcare services, can qualify as Health Homes. The role of Paramount will be one of collaboration on enrolled members to ensure the highest level of integration of behavioral health and medical healthcare services through clinical information sharing, improved access to care, and coordination of benefits.

**Lucas County Certified Ohio Medicaid Health Home Service Providers**

- **Harbor**
  - 6629 West Central Ave., Toledo, OH 43617
  - (419) 475-4449

- **Unison Behavioral Health**
  - 544 E. Woodruff Ave., P.O. Box 10015
  - (419) 936-7386

- **Zepf Center**
  - 6605 Central Ave., Toledo, OH 43617
  - (419) 841-7701 Ext. 1178

**Who will be eligible for Health Home services in community behavioral health centers?**

Adults and children who have Medicaid benefits and meet the State of Ohio definition of SPMI and SED. This includes adults with SPMI and children with SED less than 18 years of age. Participation in the program is voluntary and covered under an individual’s current Medicaid plan.

**Who will provide the Health Home services?**

- **Health Home Team**
  - Health Home Team Leader
  - Embedded Primary Care Clinician
  - Care Manager
  - Qualified Health Home Services Specialists

**Important Note:** Members may keep their established PCP while enrolled in a Health Home. In certain situations the member may benefit from receiving primary care services from the integrated PCP at the Health Home. In that case, the member may elect the Health Home PCP as his/her PCP.

**What services will be available?**

Comprehensive Care Management / Care Coordination / Health Promotion / Comprehensive Transitional Care / Individual and Family Support / Referral to Community and Social Support Services.

**For more information…**

http://www.healthtransformation.ohio.gov/CurrentInitiatives/CreateHealthHomes.aspx

Kim Kiefer, Paramount Medicaid Health Home Coordinator

(419) 887-2292

1/16/13

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1901 Indian Wood Circle | Maumee, Ohio 43537 | www.paramounthealthcare.com
CLAIMS
SECTION 8.0

PARAMOUNT
ADVANTAGE
Affiliate of ProMedica
Electronic Claims Submission

To submit claims electronically, please contact our Electronic Claims Submission system coordinator.
Telephone number: 419-887-2532 or 855-803-6777
E-mail address: PHCECSHelpDesk@promedica.org

Electronic Vendors/Clearinghouses HIPAA Compliant

Thank you for your interest in submitting claims electronically to Paramount. While we’re unable to recommend a vendor or clearinghouse, we can provide you with a list of vendors and clearinghouses that currently submit HIPAA compliant electronic files to Paramount. Please Note: This list is subject to change and is not all inclusive.

<table>
<thead>
<tr>
<th>Vendors</th>
<th>Clearinghouses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herfert Software (Eastpointe, MI)</td>
<td>HCFA, 835</td>
</tr>
<tr>
<td>Mac Computers (Toledo, OH)</td>
<td>HCFA, 835</td>
</tr>
<tr>
<td>Medical Business Systems (Cleveland, OH)</td>
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<tr>
<td>Netsoft</td>
<td>HCFA, 835</td>
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<tr>
<td>TriMed (Flint, MI)</td>
<td>HCFA, 835</td>
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<tr>
<td>Universal Software</td>
<td>HCFA (DME)</td>
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<tr>
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### Example Electronic Claims Report

The file name to ask your vendor/clearinghouse to forward to you after each claim submission is **RPT/ERR**. This file is sent to the vendor/clearinghouse within 48 hours of submission. Be sure to work with your vendor to receive your reports.

**Example**

#### Confirmation Section

<table>
<thead>
<tr>
<th>RECORD#</th>
<th>CLAIM#</th>
<th>MEMBER#</th>
<th>FIRST NAME</th>
<th>LAST NAME</th>
<th>DOS</th>
<th>TOT CHG</th>
<th>PROV#</th>
<th>NPI#</th>
<th>TAX ID</th>
<th>TRACE #</th>
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<tbody>
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<td>080513095090</td>
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<td>DOROTHY</td>
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<td>$5,300.00</td>
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<td>0000754871</td>
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</table>

**BATCH STATISTICS**

<table>
<thead>
<tr>
<th>TOTAL CLAIMS</th>
<th>TOTAL DOLLARS</th>
<th>CLAIMS WITH ERRORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>11,820.00</td>
<td>1</td>
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#### Error Section

<table>
<thead>
<tr>
<th>MEMBER#: 4446663333</th>
<th>MEDICAL RECORD#: 777711</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER: JOHN XXXXX</td>
<td>PHYSICIAN:</td>
</tr>
<tr>
<td>DOS: 20080507</td>
<td>PROVIDER#: 111111111111 (NPI)</td>
</tr>
<tr>
<td>TOTAL CHG: $190.00</td>
<td>TAX ID: 3411111111</td>
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<td>TRACE#: 20080514003237699458</td>
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<tr>
<td>FIELD VALUE: 4446663333</td>
<td>ERR MSG: INVALID MEMBER NUMBER</td>
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<tr>
<td>ACCURACY PERCENT: 83.33%</td>
<td></td>
</tr>
</tbody>
</table>

The errors listed above must be corrected and the entire claim resubmitted.

The claim number indicated is for each **CLEAN** claim that was uploaded successfully. When you do not see a claim number this means we received the claim in the file, but it had an error and the claim was not uploaded to our system. The errored claim will show up on the errors page. **You will need to resubmit the entire claim electronically.**

When calling Provider Inquiry about a claim’s status, please reference the claim number for quick lookup.
Electronic Claim Submitters
Review of Rejected Claim Reports

It is important that you review both Level I and Level II ECS Rejected Claim Reports as detailed below.  
*Rejected claims need to be corrected and resubmitted.*

### LEVEL I
**SUMMARY REPORT (FACILEDI)**

- When an electronic claims file is submitted to Paramount it will immediately run through a Claredi Faciledi server, which checks each claim for HIPAA compliance.  (This is a report to help your office maintain HIPAA compliance.)
- If a single claim is found to be non-compliant, it will be rejected back to the submitter immediately on a Summary Report. This report will be placed in the submitter’s electronic outbox.
- The file name for the Summary Report is RPTSUB (or RPTTXT if receiving it in the text version).
- Faciledi rejected claims will **NOT** run through our processing system.

<table>
<thead>
<tr>
<th>PROVIDERS SUBMITTING DIRECTLY</th>
<th>PROVIDERS SUBMITTING THROUGH CLEARINGHOUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will most likely need to retrieve this report yourselves and review it yourselves.</td>
<td>Your clearinghouse is responsible for retrieving this report.</td>
</tr>
<tr>
<td>If you are not already doing so, please look to your vendor for direction.</td>
<td>They should be making it available to your office.</td>
</tr>
</tbody>
</table>

**ALL PROVIDERS:** Whether you retrieve the Faciledi (Level I) reports yourselves or your clearinghouse retrieves them, you are ultimately responsible for making sure the rejected claims are resubmitted. Claims need to be resubmitted electronically.

### LEVEL II
**WORK OFF ERRORS & RESUBMIT**

- An Error/Confirmation Report, a.k.a. Work Off Errors and Resubmit, is created for each electronic file uploaded. Files are uploaded M-F at 3:15 pm. The Work Off Errors report for claims uploaded is usually generated the next day. The report is automatically posted in the submitter’s electronic outbox. The file name is RPTERR.
- This report checks for errors that are non-HIPAA related, such as invalid member number or invalid provider number.
- This report lists all claims which passed the Level I edits.

<table>
<thead>
<tr>
<th>PROVIDERS SUBMITTING DIRECTLY</th>
<th>PROVIDERS SUBMITTING THROUGH CLEARINGHOUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will most likely need to retrieve these files yourselves if you are not already doing so.</td>
<td>Your clearinghouse will be retrieving these reports.</td>
</tr>
<tr>
<td>Please see your vendor for direction on how to access them.</td>
<td>They should be making them available to your office.</td>
</tr>
</tbody>
</table>

**ALL PROVIDERS:** You are ultimately responsible for making sure you are receiving your Work Off Errors and Resubmit (Level II) report and resubmitting rejected claims. Claims need to be resubmitted electronically.

If you have questions, you may call the ECS Helpdesk at:

(419) 887-2532

VISIT US ON THE WEB: http://www.paramounthealthcare.com
Claims Submission Information

**CMS 1500 Form**
Paramount requires all physicians to submit claims on a CMS 1500 form. To follow is a copy of the CMS 1500 form and instructions.

**NPI Number**
NPI number required in box 24j – rendering NPI number. Leave blank if same as billing NPI number.
NPI number required in box 33a – billing NPI number.

**Address**
Paramount
P. O. Box 497
Toledo, OH 43697-0497
Attn: Claims Department
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable by law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS. A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate as to the facts of the case: a Medicare claim, the patient’s signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the patient has employer group health insurance, liability, no-fault, worker’s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 22.3(e) if the patient’s signature indicates that the claim is for CHAMPUS payment, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier or the CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient’s sponsor should be provided in those items captioned “Insured,” i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me. I further certify that to my professional knowledge and belief, I was at all times during the period covered by this claim provided such services or components of such services as I have described hereon, and that such services were not part of a series of services rendered to the same patient by the same physician or any other person or persons.

For services to be considered as “incident” to a physician’s professional service, 1) they must be rendered under the physician’s immediate personal supervision by his/her employee, 2) they must be an integral part of a covered physician’s service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of nonphysicians must be included on the physician’s bill.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the Uniformed Services. I further certify that the services rendered were for a Black Lung-related disorder.

No part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or fails to report essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 2653(a), 1962, 1967 and 1974 of the Social Security Act as amended, 42 CFR 411.29(a) and 422.9(a)(6), and 44 USC 3101-41 41 CFR 101 et seq. and 10 USC 1079 and 1081, 32 USC 3101 et seq., and 30 USC 961 et seq., 30 USC 123, 30 USC 133, 30 USC 135, 30 USC 3067.

The information we obtain to complete claims under these programs is used by you to identify and determine your eligibility. It is used only to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies for the effective administration of Federal provisions that require other third parties payors to pay primary to Federal program, and as otherwise necessary to administer those programs. For example, it may be necessary to disclose information about the benefits you have used in a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.


FOR CHAMPUS CLAIMS: “PRINCIPAL PURPOSES,” To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Department of Veterans Affairs, the Department of Health and Human Services and to the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions brought in the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; to the Dept. of Justice for representation of the OSI in response to the request of the person to whom a record pertains. Appropriate disclosures may be made to other states, local, foreign governments agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be obtained an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1129B of the Social Security Act and 31 USC 3302, 2012 provide penalties for withholding this information.

You should be aware that P.L. 103-533, the “Computer Matching and Privacy Protection Act of 1999,” permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX Plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: For the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.
## HCFA 1500 Guidelines

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Description</th>
<th>Field Type</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Program</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s ID Number</td>
<td>Required</td>
<td>* Patient Contract #</td>
</tr>
<tr>
<td>2</td>
<td>Patients Name</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patients Birth Date and Sex</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name (Last, First, Middle Initial)</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patients Address</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patients Relationship to Insured</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Patients Status</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td>Required</td>
<td>Name of other insurance carrier</td>
</tr>
<tr>
<td>9a</td>
<td>Other Policy or Group Number</td>
<td>Required When Applicable</td>
<td></td>
</tr>
<tr>
<td>9b</td>
<td>Date of Birth/Sex</td>
<td>Required if 9a is Answered</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>Employer Name</td>
<td>Required if 9a is Answered</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan or Program Name</td>
<td>Required if 9a is Answered</td>
<td></td>
</tr>
<tr>
<td>10a-c</td>
<td>Patient Status</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>10d</td>
<td>Reserved for Local Use</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Signature</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Signature</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness, Injury, Pregnancy</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Same or Similar Illness</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Date Patient Unable to Work in Current Occupation</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Physician</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>NPI</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Reserved for Local Use</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Medicaid Resubmission</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>24a-c</td>
<td>Dates of Service</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24b</td>
<td>Place of Service</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24c</td>
<td>EMG</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, Services or Supplies</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24e</td>
<td>Diagnosis Pointer</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24g</td>
<td>Days or Units</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24h</td>
<td>EPSDT/Family Plan</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>24i</td>
<td>ID Qual./NPI</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>24j</td>
<td>Rendering Provider ID Number</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Patient Account Number</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Name and Address of Facility Where Services Were Rendered</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Physician’s Supplier’s Billing Name, Address, Zip Code, and Phone Number</td>
<td>Required</td>
<td></td>
</tr>
</tbody>
</table>
## Obstetrical Billing Guide

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Appropriate E&amp;M Code + TH Modifier for each visit</strong></td>
</tr>
<tr>
<td></td>
<td>Routine Antepartum Office Visit (from the confirmation of pregnancy and ending at the onset of labor, induction or Cesarean section)</td>
</tr>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean delivery only</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery after previous Cesarean (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum care</td>
</tr>
<tr>
<td>H1000-1003</td>
<td><strong>Advantage product</strong> only for additional reimbursement to recognize visit complexity</td>
</tr>
</tbody>
</table>
Prescription Drug Billing Requirements

The Office of Ohio Health Plans requires that National Drug Code (NDC) information be submitted on select medical claims that itemize drugs.

To prevent any delays in claims processing, submit all claims electronically using the EDI/837 format.

For claims submitted on paper, use the following billing instructions.

**CMS-1500**

- Use field 24D to list the CPT/HCPCS code
- Immediately above, list the NDC code related to the line item CPT/HCPCS codes

**UB-04**

- Place revenue code in field 43
- Use field 43 description lines 1-23 to enter the NDC code
- Enter the CPT/HCPCS code in field 44

**To Report Medicaid Drug Data (NDC)**

- The first two positions left-justified are N and 4. N4 is the qualifier that identifies the number that follows is the NDC code.
- The next 11 positions immediately following the N4 are the NDC code of the drug in 5-4-2 format with no hyphens.

- The next two positions immediately following the last digit of the NDC code is the **unit qualifier**. Report the appropriate unit modifier from the following list.
  - F2 – Internal unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit

- The **unit quantity** immediately follows the unit qualifier. The decimal point is floating and the numbers to the right of the decimal point are restricted to 3.

- **Example:** N412345678901GR1.25 = NDC code of 12345-67-8901 with units of 1.25 grams

---

1 CPT/HCPCS DEFINED BY MCD AS REQUIRING NDC CODE
2 INGENIX 2010 UNIFORM BILLING EDITOR – FL 43
## Timely Filing Guidelines

Paramount Advantage claims must be filed 365 days from the date of service.

<table>
<thead>
<tr>
<th>What the Provider’s Office Can do to Avoid Timely Filing Denials</th>
<th>Who to Call at Paramount</th>
</tr>
</thead>
<tbody>
<tr>
<td>When filing electronically, the office must review Paramount’s confirmation/error reports. The number of claims submitted should match the number of claims listed on the confirmation report. Claims that appear on the error report have not been accepted into our system. These must be corrected and resubmitted within timely filing guidelines.</td>
<td>After checking/reviewing the confirmation/error report, if the number of claims submitted does not equal the number of claims received – call the ECS coordinator at 419-887-2532</td>
</tr>
<tr>
<td>When submitting paper claims, there should be a 30–45-day waiting period before calling Paramount for status of claims.</td>
<td>Claim status – Provider Inquiry – Phone – 419-887-2564 or 888-891-2564 Fax – 419-887-2014 or 866-768-5372</td>
</tr>
<tr>
<td>After receiving the Explanation of Payment (EOP), the office should review the denial codes, noting that the definitions of the denial codes are at the end of the EOP. These definitions are to assist your office in determining if any further action is needed (i.e., submitting chart notes, medical appeals or claim adjustments, etc.).</td>
<td>Unclear/unknown denial codes Contact Provider Inquiry as above</td>
</tr>
<tr>
<td>An office should always anticipate any staff changes, computer related problems, etc., that may delay timely filing of claims.</td>
<td>To advise Paramount of anticipated delays in claims submission – Contact your Provider Relations representative at 419-887-2535 or 800-891-2542</td>
</tr>
<tr>
<td>Information from other sources, such as hospitals, medical record departments, other physicians, ancillary providers, etc., should be obtained as quickly as possible in order to submit claims within the time frame.</td>
<td></td>
</tr>
</tbody>
</table>
Coordination of Benefits

Secondary Payor Principles

1. In no case will the total provider payment exceed the maximum payment allowance that would be reimbursed in the event the health plan was the primary payer.

2. Contractual allowances or discounts afforded to a primary payer may not be billed to Paramount health plan as the secondary payer.

3. Within Ohio Department of Medicaid (MCD) regulation 5101:3-26-09.1(3) the MCD is the payor of last resort when a member has third party resources available for payment of medical expenses for Medicaid-covered services, except for the resources written below:
   (a) Resources provided through children with medical handicaps program under Title V of the Social Security Act.
   (b) Resources that are exempt from primary payor status under Title XIX of the Social Security Act.
   (c) Resources provided through the state-sponsored program awarding reparations of victims of crime.

Advantage to Pay as Primary

It is the policy of the plan to require providers to comply and provide one of the following for Advantage to pay as primary:

- The provider has submitted the claim to the primary payer at least once, and has not received remittance advice or other communication within 90 days of the submission. Providers must be able to document the claim submission along with the dates. The plan does expect to see an ECS log or documentation that the claim was sent to the primary payer with no response.
- The provider has confirmed there is a private health insurance (other than Medicaid or Medicare); however, they cannot bill the primary insurer because the member has refused to cooperate in the collection effort (does not provide the primary information). The provider must take reasonable measures to ascertain from the member whether any third-party resources are available and if so, appropriately file a claim with that carrier. The provider must submit to the plan copies of three letters sent to the member or returned mail showing that information has been requested from the member regarding the primary carrier. System logs are not acceptable documentation.
  - The provider has obtained written documentation from the primary payer that indicates a valid reason for non-payment for the service(s) not related to a provider error including documentation from an automated system, a member’s benefit reference guide or manual, and/or partial payment of the service and the remittance advise received.

Valid reasons for non-payment from a third-party payer to the provider include, but are not limited to:

- The services were not covered under the member’s benefits
- The member did not have coverage on date services were rendered
- The primary payer considered the billed charges, and they were applied, in whole or in part, to the member’s liability (remittance advise is required)
- The member has not met the required waiting period or residency requirements for the primary benefits, or was non-compliant with the primary requirements in order to maintain coverage
- The dependent does not have coverage under the individual policy
- The member has reached the lifetime max for the medical service (primary remittance is required)
- The primary payer is disputing or contesting his/her liability to pay the claim or cover the service(s) that was rendered
Electronic Payment and Remittance Services (Emdeon™)

Paramount is contracted with Emdeon to deliver Electronic Funds Transfer (EFT) services and Electronic Remittance Advice (ERA) files in PDF image format.

Emdeon ePayment Saves Time and Expedites Cash Flow
Emdeon ePayment can reduce expenses, shorten the reimbursement cycle and streamline workflow. With access to remittance data through Emdeon Payment Manager (free with EFT enrollment), ePayment delivers electronic payment and reconciliation processes to help you and your staff eliminate paper checks, reduce costs and simplify secondary claims.

Emdeon Payment Manager Delivers Payer Remittance Data Electronically
Emdeon delivers payer remittance data electronically via Emdeon Payment Manager. Staff can quickly search, view or print each remittance as needed with Emdeon Payment Manager. This reduces time spent resolving discrepancies and inaccuracies to allow you to focus more on your patients.

Simple Enrollment
Enrollment for Emdeon ePayment is a fast, one-time process. Simply follow the instructions outlined below to begin receiving electronic payments and remittance advices today.

EFT Enrollment Instructions
New EFT Customers
Go to www.emdeon.com/eft to enroll online or call 866-506-2830 and select option 1 to enroll.

Helpful Hints for a Smooth EFT Enrollment
1. Ensure that you are an authorized representative of the designated provider.
2. Have your contact, organization and financial account information available.
3. Review all terms, pricing and authorization forms prior to submitting them to Emdeon.
5. Take advantage of the Payment Manager demo by visiting the following site: www.emdeon.com/PaymentManager/SVP/PaymentManager-SVP-Part-1.html

IMPORTANT NOTICE: Electronic distribution of payments will be funded to one bank account based on the provider tax identification number. Multiple tax IDs can be linked to the same bank account; however, a tax ID cannot be linked to multiple bank accounts. Please keep this in mind when enrolling for Paramount EFT service.

Existing EFT Customers
If you are an existing EFT customer with Emdeon and wish to add Paramount or any of our available EFT payers to your service, please call 866-506-2830 and select option 2 to speak with an enrollment representative.
Claim Adjustment/Coding Review Request

Please Note: Submission of adjustment requests will be available electronically through our website in late 2013.

Please refer to next page for complete instructions

Section 1: This section is required (PLEASE PRINT CLEARLY)
Date of Request ____________________________

Provider Name ____________________________ Provider ID Number ____________________________
NPI Number __________ Contact Name ____________________________ Phone Number ____________

Member Name ____________________________ Member ID Number ____________________________
Claim Number ____________________________ Date of Service ____________________________

Section 2: Please indicate the type of adjustment needed and include required documents.
One form per request.

Claim Correction (corrected claim required)
- Correction to units
- Correction to diagnosis code
- Correction to procedure code
- Correction to modifier
- Correction to date of service
- Correction to anesthesia time
- Correction to DRG
- Correction to place of service

Provider/Member (corrected claim required)
- Processed under incorrect provider number
- Processed under incorrect member number

COB
- Primary insurance (attach primary EOP)

Prior Authorization
- Copy of authorization attached

Timely Filing
- Subrogation/workers’ compensation – copy of WC documentation attached
- Paramount as secondary payer – copy of primary EOP attached
- Originally submitted to another carrier – copy of other carrier EOP
- Originally billed the member as self-pay – include information that indicates how/when notified that patient had Paramount
- Other type of timely filing – copy of supporting documentation attached

Sterilization/Hysterectomy/Abortion Consent/Certification – Advantage (Ohio Medicaid)
- Explain codes “BG” or “BI” (requires a corrected completed consent form JFS 03198, JFS 03199, JFS 03197)

Refund
- Overpayment (attach documentation)
- Take back (attach documentation)

Payment Amount (corrected claim required)
- Additional or late charges
- Correction to charge amount

Invoice
- Denied for invoice

Coding Review Request
- (Medical records and copy of EOP required)
- Procedure code bundling logic denial
- Denied for chart notes
- Unlisted procedure
- Service is not a duplicate

Additional Explanation:
Claim Adjustment/Coding Review Form Instructions

If Paramount has denied your claim for additional information that you feel was submitted with the original claim, please contact Provider Inquiry at 419-887-2564.

Section 1
1. All fields must be completed
2. The claim number from Paramount’s EOP
3. Paramount’s provider ID number and NPI number
4. Use one form per claim number

Section 2: Please check the most appropriate box

1. Claim Correction
   Requires a corrected claim
2. Provider/Member
   Requires corrected claim with corrected provider or member number
3. COB
   Requires a copy of primary payer EOP
4. Timely Filing
   Requires proof of initial submission as outlined on front page
5. Sterilization/Hysterectomy/Abortion Consent/Certification
   Requires a corrected completed consent form [sterilization JFS 03198, hysterectomy JFS03199, or abortion JFS03197 (Medicaid rule 5101:3-21-01/5101:3-17-01)] when denied specifically “BG” or “BI”
6. Prior Authorization
   Requires a copy of correct authorization
7. Refund
   A. Please provide full description for reason of overpayment or refund request
   B. Attach documentation
8. Payment Amount
   Requires a corrected claim
9. Invoice
   Requires copy of invoice
10. Coding Review Request
    A. Requires copy of coded chart, operative or diagnostic reports
    B. Requires a copy of the Paramount EOP

Please return this form along with required attachments to:
Paramount
P.O. Box 497
Toledo, OH 43697-0497
If you have questions concerning your submission, please contact:
Provider Inquiry at 419-887-2564, or toll free at 888-891-2564
PARAMOUNT POLICIES
SECTION 9.0

PARAMOUNT ADVANTAGE
Affiliate of ProMedica
Purpose:
To comply with the state and federal laws concerning confidentiality of protected health information (PHI) by providing guidelines for the protection of information contained in a member’s designated record set.

This policy is an overall summary of confidentiality expectations. In addition to this policy, workforce members are required to understand and adhere to all policies and procedures relating to the use and disclosure of PHI, and to seek guidance and training when necessary to resolve questions about the policies and procedures.

Definition:
Protected Health Information is information that is created or received by Paramount; and related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. PHI also either identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI pertains to both active and terminated members.

Electronic Protected Health Information (E-PHI) is PHI, as defined above, that is maintained in or transmitted by electronic media. Electronic storage media includes, but is not limited to memory devices in computers (hard drives), and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card. Electronic transmission media is used to exchange information already in electronic storage media. Transmission media includes but is not limited to: the Internet, extranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media.

Security of E-PHI is ensuring the confidentiality, integrity and availability of all E-PHI created, received, maintained or transmitted by Paramount.

Policy:
Confidentiality and protection requirements apply to oral, written and electronic PHI across the organization.

All workforce members must take reasonable steps to safeguard PHI from any intentional or unintentional use or disclosure that is in violation of this or any other Paramount policy or procedure.

Use/Disclosure
1. The use and disclosure of PHI, without the proper written authorization, or as obligated by law, is restricted to that which is necessary to carry out treatment, payment or health care operations activities and must be in accordance with Paramount’s Notice of Privacy Practices and HIPAA Policies and Procedures.
2. Disclosures of PHI will be limited to the minimum amount of information necessary to satisfy the purpose of the request and will be in accordance with any agreed to restrictions. Disclosures will not be made without verification of the identity and authority of the individual requesting the PHI.

3. Limited data sets that exclude direct identifiers of the individual or of relatives, employers, or household members of the individual may be used or disclosed for the purposes of research, public health, or health care operations of another covered entity.

4. Claim and medical data shared with fully insured employers is not implicitly or explicitly member identifiable, unless the member or member’s representative provides specific authorization. Claim and medical data shared with self insured employers is not implicitly or explicitly member identifiable, unless at least one of the following conditions is met: (1) the member or member’s representative provides specific authorization; (2) there is a signed certification from the plan sponsor that its plan documents have been amended to restrict the use and disclosure of PHI as required by the HIPAA Privacy Regulations (see Exhibit 1).

See: HIPAA-12 Minimum Necessary Uses, Disclosures and Requests for PHI
     HIPAA-11 Notice of Privacy Practices
     HIPAA-9 Authorization to Disclose Protected Health Information
     HIPAA-3 Restriction Requests on Uses and Disclosures of Protected Health Information
     HIPAA-6 Verification of Identity and Authority of Individuals to Receive Protected Health Information
     HIPAA-18 Use and Disclosure of Limited Data Sets

Section 13.2 Group Medical and Hospital Service Agreement

Safeguards

1. Access Restrictions

   Workforce Members – Access to PHI is restricted to those workforce members requiring access in order to perform their job functions.

   Subscribers/Members – Access to an individual’s designated record set is available upon written request from the member.

2. Access Controls

   Electronic PHI – Access to all of Paramount’s network and computer systems is controlled through user identification and authentication and/or physical security measures.

   Where feasible, computer devices are positioned or shielded so that screens are not visible to public areas or unauthorized staff. Users are required to lock/logout/power off computer devices when unattended. The “screen saver” feature is used to clear the workstation screen when left unattended for a brief period of time.

   All fax machines are placed in secure, non-public areas. Workforce members must routinely monitor incoming fax transmissions and promptly route to the intended receiver or the member’s designated record set.

   Written PHI – All PHI in written form is kept in locked file cabinets and is signed out on an “as needed” basis.

   Oral PHI – Workforce members are required to maintain privacy during oral discussions. PHI is not to be discussed in places where others can over hear (e.g., elevators, restrooms, break room, lobby or public places outside of Paramount’s offices).

   Building Access – All visitors to Paramount’s offices must obtain a visitors badge, log entry/exit.

   Destruction – Destruction of all forms of PHI must be performed by a method that ensures there is no possibility of reconstruction of its contents.
3. PHI Transmission
All electronic transmissions (excluding fax and voice) of PHI leaving Paramount over the Internet or any other means must be encrypted using the Paramount approved industry standard encryption software package. Workforce members are prohibited from sending emails via the Internet containing PHI unless encrypted per Policy #MIS-35.

Faxing of PHI is limited to time sensitive functions. Workforce members faxing PHI shall take reasonable steps to ensure that the fax transmission is sent to the appropriate destination.

Workforce members are prohibited from leaving internal and external voice mail messages containing PHI.

4. Business Associates/Vendors
All business associates of Paramount are required to sign and implement the provisions of the standard PHS Business Associate Agreement prior to performing a function or activity involving the use or disclosure of PHI for Paramount.

Any individual, vendor, or organization that is not considered a business associate of Paramount, but that will be exposed to PHI or potentially have access to PHI is required to sign and implement the provisions of the PHS standard confidentiality agreement and/or incorporate the PHS standard contract language in the underlying service agreement.

5. Non-Compliance Sanctions
Paramount is committed to taking and will take appropriate disciplinary measures against workforce members who violate any Paramount policy/practice concerning the privacy and/or security of PHI. The disciplinary measures taken will be consistent with the violation up to, and including possible termination.

Paramount will investigate all allegations of business associate agreement and confidentiality agreement violations and take appropriate action up to, and including termination of the relationship.

See: HIPAA-5  Record Retention and Destruction
HIPAA-8 Member Access to Personal Health Information
HIPAA-12 Minimum Necessary Uses, Disclosures and Requests for PHI
HIPAA-15 Workforce General Obligations Regarding Uses and Disclosures of Personal Health Information
HIPAA-16 Business Associate Agreement Violations
HIPAA-17 Faxing of Protected Health Information
HIPAA-19 Business Associate Agreements and Confidentiality Agreements
HR-8.1 Information Security and Confidentiality
MIS-10 Access Authorization, Modification and Deletion Procedure
MIS-13 Periodic Access Review and Security Testing Procedure
MIS-15 Standard Security Settings Procedure
MIS-31 Email Use and Retention Policy Procedure
MIS-33 Internet Use and Protocol Policy Procedure
MIS-54 Guideline for Workstation Use and Placement Procedure
OPER-2 Building Access Rights

Exceptions:
None.
**Procedure:**

1. The Privacy/Security Office is responsible for developing corporate confidentiality policies and monitoring departmental compliance with such policies.

2. See individual department procedures. Departmental Managers and Directors are responsible for assuring that workforce members comply with all corporate, departmental, and regulatory requirements regarding confidentiality of PHI.

3. On an annual basis, all workforce members will sign an employee certification statement agreeing to abide by the ProMedica Health System/Paramount Code of Business Ethics.

4. Upon hire, each new workforce member will receive an Associate Handbook that explains under the heading, “What Paramount Expects From You”, the details of confidentiality.

5. All workforce members are required to complete and pass the Paramount HIPAA training modules in accordance with HIPAA-14 Workforce Training

**Approvals:**

**President:**

**Sr. Vice President, Finance and Operations:**

**Vice President, Marketing:**

**Vice President, Medical Director:**

**Exhibit 1**

The plan sponsor’s documents must incorporate the following provisions and the plan sponsor agrees to:

1. Not use or disclose PHI other than as permitted by the plan documents or required by law

2. Ensure that agents and subcontractors of the employer or plan sponsor agree to the same restrictions and conditions as the employer or plan sponsor with regard to PHI

3. Prohibit the use of PHI by the employer or plan sponsor for employment or other benefit-related decisions

4. Notify the organization of any use or disclosure of PHI that is inconsistent with the uses and disclosures established in the plan documents

5. Allow individuals access to PHI, including access to amend PHI

6. Make necessary information available to the organization in order to provide individuals with accountings of disclosures

7. Procedures for return, destruction and restrictions of further use of PHI by employers or plan sponsors

8. Identify the sponsor’s or employer’s employees who have access to PHI

9. Include provisions for actions if the sponsor or employer’s employees inappropriately use or disclose PHI.
**Policy Title:** Notice of Action, Appeal, Grievance and State Hearings Policy

**ProMedica Policy:** Notice of Action, Appeal, Grievance and State Hearings Policy

**Applies To:** Paramount Advantage Corporation

**Effective Date:** 07/01/15 (original policy; Policy MEDCD-27 created to include ODJFS/OMD and NCQA revisions. Replaces Policy #MEDCD-11 and Policy #MDCD-19)

**Scheduled Annual Review Date:** July 1 (each calendar year)

**Purpose:**
To establish consistent, procedures related to recording and analyzing a grievance or appeal from Paramount Advantage Members. To identify opportunities for quality improvement and to assure that grievances or appeals are addressed in a thorough, confidential, timely and appropriate manner.

**Definition:**
For the purposes of this policy the following terms are defined as:

1. An “action” is Paramount’s:
   a. Denial or limited authorization of a requested service, including the type or level of service;
   b. Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by Paramount;
   c. Denial, in whole or part, of payment for a service;
   d. Failure to provide services in a timely manner as specified in Rule 5160-26-03.1 of the Ohio Administrative Code; or
   e. Failure to act within the resolution timeframes specified in this policy.

2. An “appeal” is the request for Paramount’s review of an action.

3. A “grievance” is an expression of dissatisfaction with any aspect of Paramount’s or provider’s operation, provision of health care services, activities, or behaviors, other than an action as defined above.

4. “Resolution” means a final decision is made by Paramount and the decision is communicated to the member.

5. “Notice of Action (NOA)” is the written notice Paramount must provide to members when an action has occurred or will occur.

6. “State Hearing” - If a member or authorized representative thinks there has been a mistake by Paramount Advantage, the member may ask for a state hearing. A state hearing is a meeting with the member and/or authorized representative, a representative from Paramount Advantage, and a hearing officer from the Ohio Department of Job and Family Services (ODJFS). The representative from Paramount Advantage will explain the action we have taken or want to take. The member is given a chance to tell why they think the action is wrong. The hearing officer will listen to the testimony and may ask questions to help bring out all the facts. The hearing office will review the facts presented at the hearing and recommend a decision based on whether or not the rules were correctly followed.

**Policy:**
It is the policy of Paramount Advantage to document and investigate all Paramount Advantage grievances and appeals, both medical and non-medical areas of member dissatisfaction, in a prompt, confidential manner, treating all grievances and appeal cases equitable using the following procedure. Regardless of whether a Member complains to ODM or any other public entity, Paramount Advantage will adhere to all the grievance and appeal
procedure requirements. A systematic process for aggregation and analysis of data will be done in order to identify quality improvement opportunities, to implement interventions and to measure the effectiveness of the interventions.

It is the policy of Paramount Advantage to handle all Paramount Advantage State Hearing requests in a prompt, confidential manner, treating all State Hearing requests equitably using the following procedure

Paramount’s written policies and procedures for the appeal and grievance system for members are in compliance with ODM requirements. The policies and procedures will be made available for review by ODM, and include the following:

1. A process by which members may file grievances
2. A process by which members may file appeals
3. A process by which members may access the state’s hearing system through the Ohio Department of Job and Family Services (ODJFS)

Other duties of Paramount regarding appeals and grievances.

1. Paramount will give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:
   a. Explaining Paramount’s process to be followed in resolving the member’s appeal or grievance;
   b. Completing forms and taking other procedural steps as outlined in this policy; and
   c. Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
2. Paramount will ensure that the individuals who make decisions on appeals and grievances are individuals who:
   a. Were not involved in previous levels of review or decision-making and who are not the subordinate of any person involved in the initial determination; and
   b. Are health care professionals who have the appropriate clinical expertise in treating the member’s condition or disease if deciding any of the following:
      i. An appeal of a denial that is based on lack of medical necessity;
      ii. A grievance regarding the denial of an expedited resolution of an appeal; or
      iii. An appeal or grievance that involves clinical issues.

3. The procedure to be followed to file an appeal, grievance, or state hearing request is described in the Paramount’s Member Handbook and includes the telephone number(s) for Paramount’s toll-free Member Services hotline; Paramount’s mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with Paramount. Copies of the form(s) to file an appeal or grievance are also available through Paramount’s Member Services Department.

4. Appeals and grievance procedures include the participation of individuals authorized by Paramount to require corrective action.

5. Paramount will not delegate the appeal or grievance process to another entity.

Exceptions:
None
**Procedure:**

**Notice Of Action (NOA)**

1. When an action has occurred or will occur, Paramount will provide the affected member(s) with a written NOA.

2. The NOA meets the language and format requirements for member materials specified in paragraph (B)(2) of rule 5160-26-08.2 of the Administrative Code and explains:
   a. The action Paramount has taken or intends to take;
   b. The reasons for the action;
   c. The member’s or authorized representative’s right to file an appeal with Paramount;
   d. If applicable, the member’s right to request a state hearing through the state’s hearing system;
   e. Procedures for exercising the member’s rights to appeal or grieve the action;
   f. Circumstances under which expedited resolution is available and how to request it;
   g. If applicable, the member’s right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services;
   h. The date that the notice is being issued;
   i. Oral interpretation is available for any language;
   j. Written translation is available in prevalent languages as applicable;
   k. Written alternative formats may be available as needed; and
   l. How to access Paramount’s interpretation and translation services as well as alternative formats that can be provided by Paramount.

3. Paramount will give members a written NOA within the following timeframes:
   a. For a decision to deny or limit authorization of a requested service, including the type or level of service, Paramount will issue an NOA simultaneously with the decision. (Exhibit A NOA UCM Denial Letter)
   b. For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by Paramount, Paramount will give notice fifteen calendar days before the date of action except: (Exhibit A)
      i. If probable recipient fraud has been verified, Paramount will give notice five calendar days before the date of action.
      ii. Under the circumstances set forth in 42 C.F.R. 431.213 (October 1, 2013), Paramount will give notice on or before the date of action.
   c. For denial of payment for a non-covered service, Paramount will give notice simultaneously with Paramount’s action to deny the claim, in whole or part, for a service that is not covered by Medicaid, including a service that was determined through Paramount’s prior authorization process as not medically necessary. (Exhibit B NOA Claim Denial Letter)
   d. For untimely prior authorization, service, appeal or grievance resolution, Paramount will give notice simultaneously with becoming aware of the action. (Exhibit C NOA Untimely Grievance Resolution Letter) A service authorization decision not reached within the timeframes specified Rule 5160-26-03.1 of the Ohio Administrative Code; constitutes a denial and is thus considered to be an adverse action. Notice will be given on the date that the authorization decision timeframe expires.

**Standard Appeal Process**

1. A member, provider, or a member’s authorized representative may file an appeal orally or in writing within ninety days from the date on the
NOA. The ninety day period begins on the day after the mailing date of the NOA. An oral filing must be followed with a written appeal. Paramount will:

a. Assist members that file an oral appeal by immediately converting an oral filing to a written record;

b. Ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal; and

c. Consider the date of the oral filing as the filing date if the member follows the oral filing with a written appeal.

2. Any provider acting on the member’s behalf must have the member’s written consent to file an appeal. Paramount will begin processing the appeal pending receipt of the written consent.

3. Paramount will acknowledge receipt of each appeal to the individual filing the appeal. At a minimum, acknowledgment will be made in the same manner that the appeal was filed. If an appeal is filed in writing, written acknowledgment will be made by Paramount within three working days of the receipt of the appeal. (Exhibit D Paramount Advantage Appeal Acknowledgement Letter)

4. Paramount will provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member and/or member’s authorized representative must be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.

5. Paramount will consider the member, member’s authorized representative, or estate representative of a deceased member as parties to the appeal.

6. Paramount will review and resolve each appeal as expeditiously as the member’s health condition requires but the resolution timeframe must not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in the Appeal Resolution Extension section of this policy.

7. Paramount will provide written notice to the member, and to the member’s authorized representative if applicable, of the resolution including, at a minimum, the decision and date of the resolution. (Exhibit E Paramount Advantage Appeal Resolution Letter)

8. For appeal decisions not resolved wholly in the member’s favor, the written notice to the member will also include information regarding:

a. Oral interpretation that is available for any language;

b. Written translation that is available in prevalent languages as applicable;

c. Written alternative formats that may be available as needed;

d. How to access Paramount’s interpretation and translation services as well as alternative formats that can be provided by Paramount;

e. The right to request a state hearing through the state's hearing system; and;

f. How to request a state hearing; and if applicable:

   i. The right to continue to receive benefits pending a state hearing;

   ii. How to request the continuation of benefits; and

   iii. If Paramount’s action is upheld at the state hearing that the member may be liable for the cost of any continued benefits.

9. For appeals decided in favor of the member, Paramount will:

a. Authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires if the services were not furnished while the appeal was pending.

b. Pay for the disputed services if the member received the services while the appeal was pending.
**Expedited Appeals**

1. Paramount’s expedited review process has been established to resolve appeals when Paramount determines, or the provider indicates in making the request on the member’s behalf or supporting the member’s request, that taking the time for a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function.

2. In utilizing an expedited appeal process, Paramount complies with the standard appeal process specified above, except Paramount will:
   a. Not require that an oral filing be followed with a written, signed appeal;
   b. Make a determination within one working day of the appeal request whether to expedite the appeal resolution;
   c. Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;
   d. Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;
   e. Resolve the appeal as expeditiously as the member’s health condition requires but the resolution timeframe must not exceed three working days from the date Paramount received the appeal unless the resolution timeframe is extended as outlined in the Appeal Resolution Extension section of this policy.
   f. Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification;
   g. Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member’s appeal; and
   h. Notify ODM within one working day of any appeal that meets the criteria for expedited resolution as specified by ODM.

3. If Paramount denies the request for expedited resolution of an appeal Paramount will:
   a. Transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended as outlined in the Appeal Resolution Extension section of this policy.
   b. Provide the member written notice of the denial to expedite the resolution within two calendar days of the receipt of the appeal, including information that the member can grieve the decision. (Exhibit F Paramount Advantage Expedited Appeal Letter)

**Appeal Resolution Extensions**

1. A member may request that Paramount extend the timeframe to resolve a standard or expedited appeal up to fourteen calendar days.

2. Paramount may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. Paramount will seek such an extension from ODM prior to the expiration of the regular appeal resolution timeframe and the request will be supported by documentation that the extension is in the member’s best interest. If ODM approves the extension, Paramount will immediately give the member written notice of the reason for the extension and the date by which a decision must be made. (Exhibit G Paramount Advantage Appeal Extension Approval Letter)

3. Paramount will maintain documentation of any extension request.

**Continuation Of Benefits For An Appeal**

1. Paramount will continue a member’s benefits when an appeal has been filed if the following conditions are met:
   a. The member or authorized representative files the appeal on or before the later of the following:
      i. Within fifteen working days of Paramount mailing the NOA; or
ii. The intended effective date of the proposed action;
b. The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized course of treatment;
c. The services were ordered by an authorized provider;
d. The authorization period has not expired; and
e. The member requests the continuation of benefits.

2. If Paramount continues or reinstates the member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
   a. The member withdraws the appeal;
   b. Fifteen calendar days pass following the mailing date of the notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing in which case therefore the benefits must be continued as specified in Rule 5101:6-4-01 of the Ohio Administrative Code;
   c. A state hearing regarding the continuation of the benefits reduction, suspension or termination of services is decided adverse to the member; or
   d. The initial time period for the authorization expires or the authorization service limits are met.

3. At the discretion of ODM, Paramount may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds Paramount’s original action.

Grievance Process
1. A member or authorized representative can file a grievance. An authorized representative must have the member’s written consent to file a grievance on the member’s behalf.
2. Grievances may be filed with Paramount, orally or in writing, within ninety calendar days of the date that the member became aware of the issue.

3. Paramount will acknowledge the receipt of each grievance to the individual filing the grievance. Oral acknowledgment is acceptable. However, if the grievance is filed in writing, written acknowledgment must be made within three working days of receipt of the grievance. (Exhibit H ODM Grievance Acknowledgement Letter)

4. Paramount will review and resolve all grievances as expeditiously as the member’s health condition requires. Grievance resolutions including member notification will meet the following timeframes:
   a. Within two working days of receipt if the grievance is regarding access to services.
   b. Within thirty calendar days of receipt for non-claims related grievances except as specified above in paragraph (H)(4)(a) of this section.
   c. Within sixty calendar days of receipt for claims related grievances.

5. At a minimum, Paramount will provide oral notification to the member of a grievance resolution. However, if Paramount is unable to speak directly with the member or the resolution includes information that must be confirmed in writing, the resolution will be provided in writing simultaneously with the decision. (Exhibit I ODM Grievance Resolution Letter)

6. If Paramount’s resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service or billing of a member due to Paramount’s denial of payment for that service, Paramount will notify the member of his or her right to request a state hearing as specified in the Access to State Hearing System section of this, if the member has not previously been notified.

Access To The State’s Hearing System
1. 1. Paramount’s policies and procedures ensure compliance with the state hearing provisions specified in Rule 5101:6 of the Ohio
Administrative Code.

2. Members are not required to exhaust the appeal or grievance process through Paramount in order to access the state’s hearing system.

3. When required in the Notice of Action section of this policy and Rule 5101:6 of the Administrative Code, Paramount will notify members, and any authorized representatives on file with Paramount, of the right to a state hearing. The following requirements apply:
   a. If Paramount denies a request for the authorization of a service, in whole or in part, Paramount will simultaneously complete and mail or personally deliver the “Notice of Denial of Medical Services by your Managed Care Plan” (ODM 04043, 7/2014 formerly JFS 04043). (Exhibit J ODM Notice of Denial of Medical Services By Your Managed Care Plan)
   b. If Paramount decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by Paramount, Paramount will complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination, the “Notice of Reduction, Suspension or Termination of Medical Services by your Managed Care Plan” (ODM 04066, 7/2014 formerly JFS 04066). (Exhibit K ODM Notice of Denial of Medical Services By Your Managed Care Plan)
   c. If Paramount learns that a member has been billed for services received by the member due to Paramount’s denial of payment, and Paramount upholds the denial of payment, Paramount will immediately complete and mail or personally deliver the “Notice of Denial of Payment for Medical Services by your Managed Care Plan” (ODM 04046, 7/2014 formerly JFS 04046). (Exhibit L ODM Notice of Denial of Payment For Medical Services By Your Managed Care Plan)
   d. If Paramount proposes enrollment in the Coordinated Services Program (CSP), Paramount will complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed enrollment, the “Notice of Proposed Enrollment in the Coordinated Services Program(CSP)” (ODM 01717, 7/2014 formerly JFS 01717). (Exhibit M ODM Notice of Proposed Enrollment In The Coordinated Services program (CSP))
   e. If Paramount decides to continue enrollment in CSP, Paramount will simultaneously complete and mail or personally deliver the “Notice of Continued Enrollment in the Coordinated Services Program (CSP)” (ODM 01705, 7/2014 formerly JFS 01705). (Exhibit N ODM Notice of Continued Enrollment In The Coordinated Services Program (CSP))
   f. If Paramount denies a CSP member’s request to change designated provider(s) within Paramount’s provider panel, Paramount will simultaneously complete and mail or personally deliver the “Notice of Denial of Designated Provider or Pharmacy in the Coordinated Services Program (CSP)” (ODM 01718, 7/2014 formerly JFS 01718). (Exhibit O ODM Notice of Denial of Designated Provider or Pharmacy In The Coordinated Services Program CSP))

4. The member or member’s authorized representative may request a state hearing within ninety calendar days by contacting the ODJFS Bureau of State Hearings or local county department of Job and Family Services (CDJFS). The ninety-day period begins on the day after the mailing date on the state hearing form.

5. There are no state hearing rights for a member(s) terminated from Paramount pursuant to a Paramount initiated membership termination as permitted in rule 5160-26-02.1 of the Ohio Administrative Code.
6. Following the Bureau of State Hearings’ notification to Paramount that a member has requested a state hearing Paramount will:

   a. Complete the “Appeal Summary for Managed Care Plans” (ODM 01959, 7/2014 formerly JFS 01959) with appropriate attachments, and file it with the Bureau of State Hearings at least three business days prior to the scheduled hearing date. The appeal summary will provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for Paramount’s action or decision. (Exhibit P ODM Appeal Summary For Managed Care Plans).

   b. Send a copy of the completed appeal summary to the appellant, the Bureau of State Hearings, the local agency, and the designated ODM contact.

   c. Continue or reinstate the benefit(s) specified in rule 5101:6-4-01 of the Ohio Administrative Code, if Paramount is notified that the member’s state hearing request was received within the prior notification period.

   d. Not enroll the individual in the Coordinated Services Program (CSP) if Paramount is notified that the member’s state hearing request was received within the prior notification period.

7. Paramount will participate in the hearing in person or by telephone, on the date indicated on the “State Hearing Scheduling Notice” (JFS 04002, rev. 09/2002) sent to Paramount by the Bureau of State Hearings.

8. In addition to Paramount and the member, other parties to a state hearing may include an authorized representative of a member, or the representative of the member’s estate, if the member is deceased.

9. Paramount will comply with the state hearing officer’s decision provided to Paramount via the “State Hearing Decision” (JFS 04005, rev. 03/2003). (Exhibit Q ODJFS Bureau of State Hearings Order Of Compliance Notice) If the hearing officer’s decision is to sustain the member’s appeal, Paramount will complete the “State Hearing Compliance Notice” (JFS 04068, rev. 05/2001). A copy of the completed form, including applicable documentation, will be sent no later than the compliance date specified in the hearing decision to the Bureau of State Hearings and the designated ODM contact. If applicable, Paramount will:

   a. Authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires.

   b. Pay for the disputed services if the member received the disputed services while the appeal was pending.

10. Paramount will provide a copy of the state hearing forms referenced in this policy to ODM, as directed by ODM.

11. Upon request, Paramount’s state hearing policies and procedures will be made available for review by ODM.

Logging And Reporting Of Appeals And Grievances

1. Paramount will maintain records of all appeals and grievances including resolutions for a period of eight years and the records will be made available upon request to ODM and the Medicaid Fraud Control Unit.

   a. Documentation is maintained in the Access database and in the member’s folder in EXP Maccss Service Module.

2. Paramount will identify a key staff person responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with this rule.

3. Paramount will submit information regarding appeal and grievance activity as directed by ODM.

   a. Paramount will report the number, type and resolution of appeals and grievances (in writing) on a quarterly and annual basis to the Administrative Staff. The analysis of data will be done in order to identify quality improvement opportunities, to implement interventions and to measure the effectiveness of the interventions.
Approvals:

President:

Sr. Vice President, Finance and Operations:

Vice President, Marketing:

Vice President, Medical Director:

Exhibits

Exhibit A NOA UCM Denial
Exhibit B NOA Claim Denial
Exhibit C NOA Untimely Grievance Resolution
Exhibit D PHC Adv Appeal Acknowledgement Letter
Exhibit E PHC Adv Appeal Resolution Letter
Exhibit F PHC Adv Expedited Appeal Letter
Exhibit G PHC Adv Appeal Extension Approval Letter
Exhibit H ODM Grievance Acknowledgement Letter
Exhibit I ODM Grievance Resolution
Exhibit J Notice of Denial of Medical Services by Your Managed Care Plan
Exhibit K Notice of Reduction, Suspension, or Termination of Medical Services by Your Managed Care Plan
Exhibit L Notice of Denial of Payment for Medical Services by Your Managed Care Plan
Exhibit M Notice of Proposed Enrollment in the Coordinated Services Program (CSP)
Exhibit N Notice of Continued Enrollment in the Coordinated Services Program (CSP)
Exhibit O Notice of Denial of Designated Provider or Pharmacy in the Coordinated Services Program (CSP)
Exhibit P Appeal Summary for Managed Care Plans
Exhibit Q Order of Compliance Notice
Exhibit A
NOTICE OF ACTION

Member Name:  
Member ID Number:  

We are denying your request for the following medical service(s):

[OR.... select as appropriate.]

We are proposing to reduce, suspend or terminate the following medical services(s):

«Action Taken/Services_Denied»

Reason for Decision/Action:

«Reason_for_action/denial»

The member's /authorized representative's or provider's right to file an appeal.  
If you don’t agree with this action, you, your doctor, or someone that you say can act on your behalf, can ask that we change our decision/action. This request is called an appeal. We will give you an answer within 15 calendar days of your asking for an appeal.

The procedure to exercise the rights specified.  
If you don’t agree with this action and want an appeal, please call us toll-free at 1-800-462-3589 or (419) 887-2525. If you have a hearing or speech impairment, please call us at 1-888-740-5670 or (419) 887-2526. An appeal can also be sent in writing to the mailing address listed below. Make sure to include your name, member number, and a telephone number where we can reach you. We have also told your doctor of this action and what he/she needs to do if they want to appeal this decision. If you want your doctor or someone to act on your behalf for the appeal, you must tell us this in writing.

Paramount Health Care  
1901 Indian Wood Circle  
Maumee, OH 43537-4068

Mailing Address:
Paramount Health Care  
P.O. Box 928  
Toledo, OH 43697-0928

If you agree with the decision/action but you are unhappy with the steps we and/or your doctor took to make the decision then you can also contact us to tell us why you are unhappy.
The circumstance under which expedited resolution is available and how to request it.
If you or your doctor believe that waiting up to 15 calendar days to decide your appeal could seriously risk your life or health, including your being able to reach, keep, or get back to your maximum function, you or your doctor should tell us this when asking for an appeal. If Paramount agrees, we will expedite or make a decision sooner (within 3 working days) on your appeal.

The member’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of the services.
If we are going to reduce, stop for a while, or end a service we had already approved you to receive, you can appeal the action. You have the right to keep getting the service until we make our decision on your appeal if we approved you to get the service from the doctor and the time limit we approved hasn’t passed. To keep getting the service you must ask for an appeal either on or before ten (10) working days of the mailing date of this notice or the effective date of the action. If you appeal the action and keep getting the service you may have to pay for the service if the Ohio Department of Medicaid decides that we acted correctly because of fraudulent behavior on your part.

The member’s right to request a state hearing.
You also have the right to ask for a state hearing. A hearing officer from the Ohio Department of Job and Family Services will decide if we made the right decision. If you want a state hearing, you must sign and return the enclosed form to the address listed on the form within 90 days of the mailing date of this notice.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526 for help at no cost to you. We can help to explain this information, in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.
Exhibit B
Notice of Action

Date

Name
Address
City State Zip

RE:     
ID#:   
Provider:
Date of Service: 

Dear Responsible Party:

This Notice of Action is provided by Paramount Advantage for a service(s) you or a member of your family received. This service is not a covered benefit under Medicaid.

If you don’t agree with this action, you, your provider, or someone that you say can act on your behalf, can ask that we change our decision/action. This request is called an appeal. You must ask for an appeal within 90 days after the mailing date of this notice. We will give you an answer within 15 calendar days of your asking for an appeal.

If you are being billed because we denied payment for this service, you also have the right to ask for a state hearing. A hearing officer from the Ohio Department of Job and Family Services will decide if we made the right decision. If you get a bill, please call our member services department toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526. It is important that you call as soon as you get the bill so we can help you and give you information on how you can ask for a state hearing.

If you don’t agree with this action and want an appeal, please call us toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526. An appeal can also be sent in writing to Paramount Advantage, P.O. Box 928 Toledo, OH 43697-0928, submitted via the internet at www.paramountadvantage.org or faxed to 1-888-740-0222. Make sure to include your name, member number, reasons for appealing, any information you want to attach such as medical records or provider letters, and a telephone number where we can reach you. We have also told your provider of this action and what he/she needs to do if they want to appeal the decision. If you want your provider or someone to act on your behalf for the appeal, you must tell us this in writing.

If you agree with the decision/action but you are unhappy with the steps we and/or your provider took to make the decision then you can also contact us to tell us why you are unhappy.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526 for help at no cost to you. We can help to explain the information in English or in your primary language. We may have this information printed in other languages. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

Member Services
Exhibit C

Notice of Action

DATE

NAME
ADDRESS

RE:
ID#:  
[Grievance or Appeal as applicable] Date:

Dear Responsible Party:

This Notice of Action is provided because the [Grievance or Appeal as applicable] you filed on DATE was not resolved within ## WORKING/CALENDAR days as required. Paramount Advantage did not resolve the [grievance or appeal] within the required time period because [WHY?]. Your [grievance or appeal] WAS/WILL BE resolved ON/NO LATER THAN DATE.

If you don’t agree with this action, you, or someone that you say can act on your behalf, can ask that we change our decision/action. This request is called an appeal. You must ask for an appeal within 90 days after the mailing date of this notice. We will give you an answer within 15 calendar days of your asking for an appeal.

If you don’t agree with this action and want an appeal, please call us 1-800-462-3589 TTY 1-888-740-5670. An appeal can also be faxed to 1-888-740-0222, sent in writing to Paramount Advantage, P.O. Box 928 Toledo, OH 43697-0928, or submitted via the internet at www.paramountadvantage.org. Make sure to include your name, member number, reasons for appealing, any information you want to attach, and a telephone number where we can reach you. If you want someone to act on your behalf for the appeal, you must tell us this in writing.

If you believe that waiting up to 15 calendar days to decide your appeal could seriously risk your life or health, including your being able to reach, keep, or get back to your maximum function, you should tell us this when asking for an appeal. If we agree, we will expedite or make a decision sooner (within 3 working days) on your appeal.

If you agree with the decision/action but you are unhappy with the steps we took to make the decision, then you can also contact us to tell us why you are unhappy.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526 for help at no cost to you. We can help to explain the information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

Member Service
EXHIBIT D

Notice of Action

DATE

NAME

ADDRESS

RE:

ID#: 

GP#: 

Dear Ms. :

Thank you for contacting our office. Your Appeal request was received on DATE. If you wish, you may meet with me to present your concerns. Please contact me if you wish to meet in person.

If we do not hear from you by DATE we will continue with your appeal request. You may also have someone represent you by signing an Authorization Form giving that person the right to appeal on your behalf. Please contact me at the number listed below if you wish to have someone represent you and need an Authorization Form.

Once a determination is made regarding your Appeal for coverage of WHAT you will be notified by letter within fifteen (15) calendar days from the date your Appeal request was received.

If you have any questions or concerns, please feel free to contact me toll-free at 1-800-462-3589 or 419-887-2446, Monday through Friday 8:00 a.m. to 4:30 p.m.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526 for help at no cost to you. We can help to explain the information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

NAME

TITLE

cc: PROVIDER
Exhibit E
Notice of Action

DATE

NAME
ADDRESS

RE:
ID#:  
GP#:  

Dear Ms. :

Your request for an Appeal regarding Paramount Health Care’s action of [DENIAL OF COVERAGE/REDUCTION/SUSPENSION/TERMINATION OF AUTHORIZED SERVICE/DENIAL OF CLAIM PAYMENT] for [WHAT?] has been thoroughly reviewed by [Clinical Peer, Board Certified in CERTIFICATION or by our Administrative Staff].

[Insert if applicable…[The decision is to UPHOLD/OVERTURN the decision. For uphold…The documentation submitted by WHO? Shows WHY IT IS UPHELD. For overturn…Authorization ###### has been entered to cover the service.]

Insert only for Denial or Reduction/Suspension or Termination upheld… You have the right to a state hearing. To request a state hearing you can sign the State Hearing Form mailed to you on DATE and send it to the Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 18285, Columbus OH 43218/-2825 or call 1-866-635-3748. You can also fax or e-mail your request as indicated on the form.

Insert if applicable… Please read the State Hearing notice to get information about your right to continue to get benefits until your hearing is decided. You may have to pay for what you get if the hearing officer rules against you.

Upon written request, you may obtain a copy of the specific criteria upon which the decision was based. You and/or your authorized representative are entitled to reasonable access to and copies of all documents relevant to your appeal. If you have any questions or concerns, please feel free to contact me toll-free at 1-800-462-3589 or 419-887-2446, Monday through Friday 8:00 a.m. to 4:30 p.m.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2446, Monday through Friday 8:00 a.m. to 4:30 p.m. or (419) 887-2526 for help at no cost to you. We can help to explain the information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

NAME
Member Service Appeal Coordinator

cc:   SPECIALIST
     PCP
Exhibit F
Notice of Action

Date

Name
Address

RE:
ID#:
GP#:

Dear Mr.:

Thank you for contacting our office. Your request for an expedited appeal was received on Date. Your request for an expedited appeal was accepted/not accepted.

IF Accepted - We will process your appeal as expedited. Once a determination is made regarding your Appeal for (state what is being appealed), you will be verbally notified and followed by a letter within three (3) working days from the date your Appeal request was received.

If NOT Accepted – The reason Paramount Advantage has not accepted your request for an expedited review is because (state the reason why the member did not fit criteria for expedited review). Your appeal request will be processed under the standard review timeframe of fifteen (15) calendar days. You have the right to file a grievance because your request cannot be expedited. To file a grievance, call the Member Services Department toll-free at 1-800-462-3589 or 419-887-2525.

If you wish, you may meet with me to present your concerns. Please contact me if you wish to meet in person. If we do not hear from you by (5 working days from received date), we will continue with your appeal request.

You may also have someone represent you by signing an Authorization Form giving that person the right to appear on your behalf. Please contact me at the number listed below if you wish to have someone represent you and need an Authorization Form.

Once a determination is made regarding your Appeal for coverage of removal of what was denied, you will be notified by letter within fifteen (15) calendar days from the date your Appeal request was received.

If you have any questions or concerns, please feel free to contact me toll-free at 1-800-462-3589 or 419-887-2446 or Monday through Friday 8:00 a.m. to 4:30 p.m.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or 419-887-2525. TTY users toll-free 1-888-740-5670 or 419-887-2526 for help at no cost to you. We can help to explain the information or provide the information orally, in English or in your primary language. We may have this information printed in certain other languages or in other ways. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

NAME
TITLE

Cc: Specialist
PCP
Exhibit G
Notice of Action

(Date)

(Name)
(Address)
(City, State, Zip Code)

RE: (Name)
ID#: (Number)
GP#: (Group Number)

Dear (Name of person):

Ohio Department of Job and Family Services has approved an extension of the timeframe to resolve your appeal for coverage of (requested services) by (number) of day/days.

(Reason for extension.) It is in your best interest that we have all the information prior to making a decision on your appeal.

A determination will be made on your appeal for coverage of (requested service) by (date). If you disagree with this action you have the right to file a grievance. To file a grievance contact our Member Service Department telephone number which is listed on your ID card.

If you have any questions or concerns you wish to discuss, please feel free to contact me at (telephone number) or toll-free at 1-800-462-3589, Monday through Friday 8:30 a.m. to 5:00 p.m.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or 419-887-2525, TTY users 1-888-740-5670 or 419-887-2526 for help at no cost to you. We can help to explain the information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

(Name)
(Title)

cc: provider
Exhibit H

Notice of Action

DATE

NAME

ADDRESS

RE:
ID#:
GP#:

Dear Ms.:

Thank you for contacting our office. Your Grievance was received on DATE. Once a determination is made regarding WHAT you will be notified. The notification will be within ## WORKING/CALENDAR days of the date your grievance was received.

If you have any questions or concerns, please feel free to call the Member Services Department toll free at (800) 462-3589 or (419) 887-2525 Option 2, Monday through Friday, 7:00 a.m. to 7:00 p.m. TTY users may call (888) 740-5670 or (419) 887-2526. You may also utilize Paramount’s website www.paramountadvantage.org or Paramount’s member portal, www.MyParamount.org, 24 hours a day 7 days a week. At MyParamount.org, information is available to review benefits, claims, referral authorizations and provider directories. You also have the ability to change your PCP, change your address, request new ID cards or e-mail us with questions. If you are a new subscriber or member, you can register for MyParamount.org to create a username and password.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526 for help at no cost to you. We can help to explain the information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

NAME
TITLE
Exhibit I
Notice of Action

DATE

NAME
ADDRESS

RE:
ID#: 
GRP#:

Dear Ms.:

Thank you for contacting our office on DATE. In response to your grievance we WHAT DID WE DO?

We have been unable to reach you by telephone. Please contact our office with your current telephone number.

If you have any questions or concerns, please feel free to call the Member Services Department toll free at (800) 462-3589 or (419) 887-2525 Option 2, Monday through Friday, 7:00 a.m. to 7:00 p.m. TTY users may call (888) 740-5670 or (419) 887-2526. You may also utilize Paramount’s website www.paramountadvantage.org or Paramount’s member portal, www.MyParamount.org, 24 hours a day 7 days a week. At MyParamount.org, information is available to review benefits, claims, referral authorizations and provider directories. You also have the ability to change your PCP, change your address, request new ID cards or e-mail us with questions. If you are a new subscriber or member, you can register for MyParamount.org to create a username and password.

If you have any problems in reading or understanding this information, please contact Paramount Advantage Member Services toll-free at 1-800-462-3589 or (419) 887-2525, TTY users 1-888-740-5670 or (419) 887-2526 for help at no cost to you. We can help to explain the information or provide the information orally, in English or in your primary language. We may have this information printed in certain other languages or in other ways. If you are visually or hearing-impaired, special help can be provided.

Sincerely,

NAME
TITLE
Ohio Department of Medicaid  
NOTICE OF DENIAL OF MEDICAL SERVICES BY YOUR MANAGED CARE PLAN

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<tr>
<th>Assistance Group Name</th>
<th>Assistance Group #</th>
<th>Date Mailed</th>
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</thead>
</table>

Member Name | Street Address  

MMIS Billing # | City, State, Zip  

### [MCP Name] has denied the request for [list service requested] for the above member.

**The reason for this action is:**

---

**The rule(s) that supports this action is:**

Contact **[MCP Name]** if you do not understand this notice. We can explain it. It is possible that we will change our decision or that you will agree with it.

<table>
<thead>
<tr>
<th>MCP Staff Name</th>
<th>Telephone Number</th>
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</table>

Name and Address of Managed Care Plan

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**As for a State Hearing if you want to appeal**

You can ask for a State Hearing if you disagree with our action or think we have made a mistake. At the State Hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Job and Family Services will make a decision after the hearing.

If you want a hearing, we must receive your request by this deadline: ____________

(Note: The deadline is 90 days after the Date Mailed at the top of this page. If a deadline falls on a Saturday, Sunday, or state or federal legal holiday, then the deadline is extended to the next workday.)

Follow the instructions on page 2 of this notice if you want to ask for a State Hearing. If you do not want a State Hearing, do not return the form.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). They may ask for a hearing and go to the hearing if they send us your signed authorization.

If you need legal assistance, you can contact your local bar association. If you want information on free legal services, you can contact your local legal aid office or call the Ohio State Legal Services Association, toll free at 1-800-589-5888 (a free call). You can also contact the Ohio Legal Rights Service at 1-800-282-9181 (a free call), whose goal is “to protect and advocate the rights of mentally ill persons, mentally retarded persons, developmentally disabled persons, and other disabled persons...”
Exhibit J Page 2

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<th>Assistance Group Name</th>
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State Hearing Request

If you want to ask for a State Hearing, we must receive your request by the deadline shown on Page 1 of this notice. If you do not want a state hearing, do not return this form.

**Step 1:** Read, sign, date and fill in your telephone number. Another person may sign this for you if they send us your signed authorization.

I want a State Hearing because I disagree with your action or think you are making a mistake.

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<th>Sign Here</th>
<th>Date</th>
<th>Telephone Number</th>
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**Step 2:** Optional – You may check boxes and fill in blanks to help us schedule your State Hearing.

☐ I need an interpreter, a signer, or other assistance at my State Hearing (explain): _____________________________

☐ The days/times I cannot come to a State Hearing are: _____________________________

☐ This person has agreed to help me with my State Hearing (my “authorized representative”):

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<th>Name</th>
<th>Telephone Number</th>
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<th>Address</th>
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<td>Fax</td>
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<th>City, State, Zip</th>
<th>E-mail</th>
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**Step 3:** You must choose one of the following ways to send this State Hearing request to us. We must receive this request by the deadline shown on Page 1 of this notice. You should keep proof of when and how you sent this hearing request to us.

**Mail** - Mail both pages of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

**Fax** - Fax both pages of this notice to ODJFS Bureau of State Hearings at (614) 728-9574.

**E-Mail** - E-mail the ODJFS Bureau of State Hearings at <bsh@jfs.ohio.gov>. In the subject, put “State Hearing Request.” In the message, put all of the information from the boxes at the top of this page and from Steps 1 and 2.

**Phone** - Phone the ODJFS Consumer Access Line at 1-866-635-3748. Follow the instructions for State Hearings. Mention this notice.

**Contact your caseworker** - It is better to send your request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.
Policy # MEDCD - 27
Exhibit K
Page 1

Ohio Department of Medicaid
NOTICE OF REDUCTION, SUSPENSION, OR TERMINATION OF MEDICAL SERVICES BY YOUR MANAGED CARE PLAN

<table>
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<tr>
<th>Assistance Group Name</th>
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<tr>
<th>Member Name</th>
<th>Street Address</th>
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<table>
<thead>
<tr>
<th>MMIS Billing #</th>
<th>City, State, Zip</th>
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</table>

[MCP Name]__________________________ is proposing to ☐ reduce, ☐ suspend, or ☐ stop [List Services]__________________________ for the above member, effective [Date] ________________________.

The reason for this action is:

[Blank space for explanation]

The rule(s) that supports this action is: ________________________

Contact [MCP Name] ________________________ if you do not understand this notice. We can explain it. It is possible that we will change our decision or that you will agree with it.

<table>
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<th>MCP Staff Name</th>
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Name and Address of Managed Care Plan

As for a State Hearing if you want to appeal

You can ask for a State Hearing if you disagree with our action or think we have made a mistake. At the State Hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Job and Family Services will make a decision after the hearing.

If you want a hearing, we must receive your request by this deadline: ________________________

(Note: The deadline is 90 days after the Date Mailed at the top of this page. If a deadline falls on a Saturday, Sunday, or state or federal legal holiday, then the deadline is extended to the next workday. If your hearing request is received within 15 days of the Date Mailed on this notice, we will not take the actions proposed in this notice until the services that were authorized are received or until your hearing is decided, whichever date comes first. You may have to pay for services you receive after the proposed effective date if the hearing officer agrees with our action.)

Follow the instructions on page 2 of this notice if you want to ask for a State Hearing. If you do not want a State Hearing, do not return the form.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). They may ask for a hearing and go to the hearing if they send us your signed authorization.

If you need legal assistance, you can contact your local bar association. If you want information on free legal services, you can contact your local legal aid office or call the Ohio State Legal Services Association, toll free at 1-800-589-5888 (a free call). You can also contact the Ohio Legal Rights Service at 1-800-282-9181 (a free call), whose goal is “to protect and advocate the rights of mentally ill persons, mentally retarded persons, developmentally disabled persons, and other disabled persons...”

Distribution: Original to Client; One copy to MCP file; One copy to the Bureau of Managed Care, ODM

ODM 04066 (1/2015) formerly JFS 04066

Page 1 of 2
State Hearing Request

If you want to ask for a State Hearing, we must receive your request by the deadline shown on Page 1 of this notice. If you do not want a state hearing, do not return this form.

Step 1: Read, sign, date and fill in your telephone number. Another person may sign this for you if they send us your signed authorization.

I want a State Hearing because I disagree with your action or think you are making a mistake.

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Step 2: Optional – You may check boxes and fill in blanks to help us schedule your State Hearing.

☐ I need an interpreter, a signer, or other assistance at my State Hearing (explain):

☐ The days/times I cannot come to a State Hearing are:

☐ This person has agreed to help me with my State Hearing (my “authorized representative”):

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</table>

Step 3: You must choose one of the following ways to send this State Hearing request to us. We must receive this request by the deadline shown on Page 1 of this notice. You should keep proof of when and how you sent this hearing request to us.

Mail - Mail both pages of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Fax - Fax both pages of this notice to ODJFS Bureau of State Hearings at (614) 728-9574.

E-Mail - E-mail the ODJFS Bureau of State Hearings at <bsh@jfs.ohio.gov>. In the subject, put “State Hearing Request.” In the message, put all of the information from the boxes at the top of this page and from Steps 1 and 2.

Phone - Phone the ODJFS Consumer Access Line at 1-866-635-3748. Follow the instructions for State Hearings. Mention this notice.

Contact your caseworker - It is better to send your request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.
NOTICE OF DENIAL OF PAYMENT FOR MEDICAL SERVICES
BY YOUR MANAGED CARE PLAN

[Assistance Group Name] [Assistance Group #] [Date Mailed]

[Member Name] [Street Address]

[MMIS Billing #] [City, State, Zip]

[Name of MJCP] has denied payment for [list medical service denied] for the above member.

The reason for this action is:

The rule(s) that supports this action is:

Contact [Name of MJCP] [Telephone Number] if you do not understand this notice. We can explain it. It is possible that we will change our decision or that you will agree with it.

Name and Address of Managed Care Plan

Ask for a State Hearing if you want to appeal

You can ask for a State Hearing if you disagree with our action or think we have made a mistake. At the State Hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Job and Family Services will make a decision after the hearing.

If you want a hearing, we must receive your request by this deadline: ____________________________.

(Note: The deadline is 90 days after the Date Mailed at the top of this page. If a deadline falls on a Saturday, Sunday, or state or federal legal holiday, then the deadline is extended to the next workday.)

Follow the instructions on page 2 of this notice if you want to ask for a State Hearing. If you do not want a State Hearing, do not return the form.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). They may ask for a hearing and go to the hearing if they send us your signed authorization.

If you need legal assistance, you can contact your local bar association. If you want information on free legal services, you can contact your local legal aid office or call the Ohio State Legal Services Association, toll free at 1-800-589-5888 (a toll free). You can also contact the Ohio Legal Rights Service at 1-800-282-9181 (a toll free), whose goal is “to protect and advocate the rights of mentally ill persons, mentally retarded persons, developmentally disabled persons, and other disabled persons…”

Distribution: Original to Client; one copy to MJCP file; one copy to the Bureau of Managed Care, ODM

ODM 04046 (7/2014)
Formerly JFS 04046

Page 1 of 2
State Hearing Request
If you want to ask for a State Hearing, we must receive your request by the deadline shown on Page 1 of this notice. If you do not want a state hearing, do not return this form.

Step 1 Read, sign, date and fill in your telephone number. Another person may sign this for you if they send us your signed authorization.

I want a State Hearing because I disagree with your action or think you are making a mistake.

<table>
<thead>
<tr>
<th>Sign Here</th>
<th>Date</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

Step 2 Optional – You may check boxes and fill in blanks to help us schedule your State Hearing.

- I need an interpreter, a signer, or other assistance, at my State hearing (explain):
  
- The days/times I cannot come to a State Hearing are:

- This person has agreed to help me with my State Hearing (my “authorized representative”):

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Fax</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td>E-Mail</td>
</tr>
</tbody>
</table>

Step 3 You must choose one of the following ways to send this State Hearing request to us. We must receive this request by the deadline shown on Page 1 of this notice. You should keep proof of when and how you sent this hearing request to us.

Mail - Mail both pages of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Fax - Fax both pages of this notice to ODJFS Bureau of State Hearings at (614) 728-9574.

E-Mail - E-mail the ODJFS Bureau of State Hearings at <bsh@jfs.ohio.gov>. In the subject, put “State Hearing Request.” In the message, put all of the information from the boxes at the top of this page and from Steps 1 and 2.

Phone - Phone the ODJFS Consumer Access Line at 1-866-635-3748. Follow the instructions for State Hearings. Mention this notice.

Contact your caseworker - It is better to send your request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.
Ohio Department of Medicaid

NOTICE OF PROPOSED ENROLLMENT IN THE COORDINATED SERVICES PROGRAM (CSP)

<table>
<thead>
<tr>
<th>Consumer Name</th>
<th>Assistance Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Assistance Group #</th>
<th>Billing #</th>
<th>City, State, Zip Code</th>
<th>County</th>
<th>Mail Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

The Ohio Department of Medicaid (ODM) or your managed care plan (MCP) is proposing your enrollment into the Coordinated Services Program (CSP) for ___ months. This means, you will receive certain medical services through designated providers. The reason for this action is ODM or your MCP has identified you as getting medical services exceeding medical necessity. The rule supporting this action is Ohio Administrative Code rule 5160-20-01.

You have 30 days from the mail date above to choose: a pharmacy and/or a designated provider through which to receive your medical services. If you don’t choose a pharmacy and/or designated provider, ODM or the MCP will pick one for you. To choose your provider, or if you do not understand this notice, call the number on your Medicaid card or on your managed care card for more information. It is possible we may change our decision or that you may decide to agree with it.

**IF YOU DISAGREE WITH THIS DECISION, YOU MAY REQUEST A STATE HEARING.**

You can ask for a State Hearing if you disagree with this action or think being enrolled in the CSP is a mistake. If you ask for a hearing within 15 days of the mail date above, neither ODM nor the MCP will enroll you into the CSP until the hearing decision is decided.

If you want a hearing, State Hearings must receive your request within 90 days after the mail date above. If the 90th day falls on a holiday or weekend, the deadline will be the next work day. If you need legal help with your hearing, you can contact your local bar association. If you want information on free legal help, you can contact your local legal aid office, or call Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO). If someone is helping you with your case, State Hearings will need a signed “authorized representative” notice from you saying it is okay for that person to represent you for the hearing process.

If you need legal help with your hearing, you can contact your local bar association. If you want information on free legal help, you can contact your local legal aid office, or call Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO). If someone is helping you with your case, the Bureau of State Hearings will need a signed “authorized representative” notice from you saying it’s okay for that person to represent you for the hearing process.

**Step 1:** Read, sign, date, and fill in your telephone number. Use the checkbox below if you need an interpreter. Another person may sign this for you, if they send us your signed “authorized representative” notice along with this state hearing request.

<table>
<thead>
<tr>
<th>I need an interpreter at my state hearing.</th>
<th>Date</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 2:** State Hearings must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us. Please only submit your hearing request one time.

- Email - Email State Hearings at bsh@ifs.ohio.gov. In the subject, put “State Hearing Request”. In the message, put all of the information from the boxes at the top of this page and “CSP hearing request”; or
- Phone - Phone the Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or
- Fax - Fax this page to State Hearings at (614) 728-9574; or
- Mail - Mail this page to State Hearings, P.O. Box 162925, Columbus, Ohio 43218-2025, or

Contact your caseworker - It is better to send this request using one of the other methods above. You may give this page (completed and signed) to your caseworker or, you may phone your caseworker, mention this notice.

On the Day of the State Hearing: You or someone else helping you with your case, can explain the reason(s) why you don’t think the decision is right. ODM or the MCP will explain its reasons. Then, a State Hearings officer will make a decision after the hearing.

Distribution: Original to Client; one copy to MCP file (for MCP members); one copy to the BMC/ODM

ODM 01717 (7/2014)
Formerly JFS 01704
**NOTICE OF CONTINUED ENROLLMENT IN THE COORDINATED SERVICES PROGRAM (CSP)**

<table>
<thead>
<tr>
<th>Consumer Name</th>
<th>Assistance Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Assistance Group #</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>Billing #</td>
</tr>
<tr>
<td></td>
<td>Mail Date</td>
</tr>
</tbody>
</table>

The Ohio Department of Medicaid (ODM) or __________________________ your managed care plan (MCP) is continuing your enrollment in the Coordinated Services Program (CSP) for an additional ___ months. This means, you will receive certain medical services through: a pharmacy and/or designated ______________________ provider. The reason for this action is ODM or your MCP has continued to identify you as getting medical services exceeding medical necessity. The rule supporting this action is Ohio Administrative Code rule 5160-20-01.

If you do not understand this notice, call the phone number on your Medicaid card or on your managed care card for more information. It is possible we may change our decision or that you may decide to agree with it.

**IF YOU DISAGREE WITH THIS DECISION, YOU MAY REQUEST A STATE HEARING.**

You can ask for a State Hearing if you disagree with this action or think being re-enrolled into the CSP is a mistake.

If you want a hearing, State Hearings must receive your request within 90 days after the mail date above. If the 90th day falls on a holiday or weekend, the deadline will be the next work day.

If you need legal help with your hearing, you can contact your local bar association. If you want information on free legal help, you can contact your local legal aid office, or call Ohio Legal Services toll free at 1-866-635-3748 (1-866-LAW-OHIO). If someone is helping you with your case, State Hearings will need a signed “authorized representative” notice from you saying it is okay for that person to represent you for the hearing process.

**Step 1:** Read, sign, date, and fill in your telephone number. Use the checkbox below if you need an interpreter. Another person may sign this for you, if they send us your signed “authorized representative” notice along with this state hearing request.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ I need an interpreter at my state hearing.

**Step 2:** State Hearings must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us. **Please only submit your hearing request one time.**

- **Email** - Email State Hearings at bsh@jfs.ohio.gov. In the subject, put “State Hearing Request”. In the message, put all of the information from the boxes at the top of this page and also put “CSP hearing request”; or
- **Phone** - Phone the Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or
- **Fax** - Fax this page to State Hearings at (614) 728-9574; or
- **Mail** - Mail this page to State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825; or
- **Contact your caseworker** - It is better to send this request using one of the other methods above. You may give this page (completed and signed) to your caseworker or, you may phone your caseworker; mention this notice.

**On the Day of the State Hearing:** You or someone else helping you with your case, can explain the reason(s) why you don’t think the decision is right. ODM will explain its reasons. Then, a State Hearings officer will make a decision after the hearing.

**Distribution:** Original to Client; one copy to MCP file (for MCP members); one copy to the BMC/ODM
Ohio Department of Medicaid

NOTICE OF DENIAL OF DESIGNATED PROVIDER OR PHARMACY IN THE COORDINATED SERVICES PROGRAM (CSP)

<table>
<thead>
<tr>
<th>Consumer Name</th>
<th>Assistance Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Assistance Group #</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>Billing #</td>
</tr>
<tr>
<td>Mail Date</td>
<td>County</td>
</tr>
</tbody>
</table>

The Ohio Department of Medicaid (ODM) or _____________________________ your managed care plan denied the request for your provider __________________________________________________. The reason for this denial is:
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

The rule supporting this action is the Ohio Administrative Code rule 5160-20-01. If you do not understand this notice, call the phone number on your Medicaid card or on your managed care card for more information. It is possible we may change our decision or that you may decide to agree with it.

**IF YOU DISAGREE WITH THIS DECISION, YOU MAY REQUEST A STATE HEARING.**

You can ask for a State Hearing if you disagree with this action or think being denied your choice of provider for CSP is a mistake.

If you want a hearing, State Hearings must receive your request within 90 days after the mail date above. If the 90th day falls on a holiday or weekend, the deadline will be the next work day.

Step 1: Read, sign, date, and fill in your telephone number. Use the checkbox below if you need an interpreter. Another person may sign this for you, if they send the Bureau of State Hearings your signed “authorized representative” notice along with this state hearing request.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] I need an interpreter at my state hearing.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 2: State Hearings must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. Please only submit your hearing request one time.

- **Email** - Email State Hearings at bsh@jfs.ohio.gov. In the subject, put “State Hearing Request”. In the message, put all of the information from the boxes at the top of this page and “CSP hearing request”; or
- **Phone** - Phone the Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or
- **Fax** - Fax this page to State Hearings at (614) 728-9574; or
- **Mail** - Mail this page to State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825; or
- **Contact your caseworker** - It is better to send this request using one of the other methods above. You may give this page (completed and signed) to your caseworker or, you may phone your caseworker; mention this notice.

On the Day of the State Hearing: You or someone else helping you with your case, can explain the reason(s) why you don’t think the decision is right. ODM will explain its reasons. Then, a State Hearings officer will make a decision after the hearing.

Distribution: Original to Client; one copy to MCP file (for MCP members); one copy to the BMC/ODM

ODM 01718 (7/2014)
Formerly JFS 01718
OHIO DEPARTMENT OF MEDICAID
APPEAL SUMMARY FOR MANAGED CARE PLANS

Information in this appeal summary is provided with the knowledge that it will be used in reaching a decision on the issue raised in the appeal and will be made available to the appellant and the appellant’s authorized representative.

Instructions: MCPs must provide all requested information and attach all documentation which supports the MCP’s action. Documentation should include 1) a complete description of the facts and circumstances upon which the MCP action was based; 2) copies of all relevant information the MCP used to make their decision and; 3) copies of all relevant correspondence, including hearing notices issued to the member.

<table>
<thead>
<tr>
<th>Appellant’s Name</th>
<th>MCP Member’s Name (if different from appellant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMIS Billing Number of MCP Member</td>
<td>Assistance Group Number</td>
</tr>
<tr>
<td>Hearing Date</td>
<td>State Hearing Appeal Number</td>
</tr>
<tr>
<td>Appellant’s Phone Number (with area code)</td>
<td>County</td>
</tr>
</tbody>
</table>

Was a state hearing notice previously sent to the member? If yes, attach a copy. If no, provide the following information:

Action taken by MCP: __________________________________________

Reason for action: __________________________________________

________________________________________________________________________

Supporting Regulation: __________________________________________

If the MCP’s action is the reduction, suspension, or termination of the provision of a previously authorized service, has the action been taken? If yes, give date: __________________________

Name of Individual preparing the appeal summary | Title of individual

______________________________ | ________________________________

Telephone Number | Date

Distribution: Original to local agency; one copy to appellant; one copy to district hearings section; one copy to MCP file; one copy to ODM, Bureau of Managed Health Care

ODM 01959 (7/2014)
Formerly JFS 01959
ORDER OF COMPLIANCE NOTICE

In the matter of: {XXX} {XXX}
Assistance Group: {XXX} {XXX}

Case Number: {XXXXXXX} County: {XXXXXXX}

Appeal Number: {XXXXXX} Program: {XXX} Disposition: {XXX}

Request Date: {XX/XX/XX} Mail Date: {XX/XX/XX}

Compliance for food assistance is due no later than: {XX/XX/XX} + 10 days, or {XX/XX/XX}+60 days, whichever is lower

Compliance for all other public assistance is due no later than: {XX/XX/XX} + 15 days, or {XX/XX/XX}+90 days, whichever is lower

This notice hereby requires the agency to comply with the {state hearing officer’s, administrative appeal reviewer’s, court} order of compliance as required by 5101.6-7-03 of the Ohio Administrative Code. Failure to respond by the compliance due date above may result in further action, as permitted under sections 5101.35(D) and 5101.24 of the Ohio Revised Code.

This is to certify that {XXXXXXX} has complied with the order of the above referenced decision.

{XXXXXXX} must provide a complete description of the compliance action(s), including the exact dates on which benefits were mailed or otherwise furnished:

Important Notice: The compliance associated with this {state hearing decision, administrative appeal decision, judicial review decision} must be reported by completing this form and uploading it directly into HATS X. All required authorization documents, hearing notices (e.g. approval notices, denial notices and prior notices) and other documentation of compliance must be attached.

List of attached documents:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Title</th>
</tr>
</thead>
</table>

JFS 04068 (Rev. 1/2015)
## Medical Record Documentation Standards – Adult

*Paramount Care, Inc. | Paramount Advantage | Paramount Elite | Paramount Care of Michigan, Inc.*

<table>
<thead>
<tr>
<th>Standard</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> General Requirements</td>
<td></td>
</tr>
<tr>
<td>1 Oversight of medical records system</td>
<td>• There is a designated staff person who is qualified by training or experience for the oversight of, and access to, the medical records system.</td>
</tr>
<tr>
<td>2 Medical records confidentiality policy</td>
<td>• Provider site maintains a policy regarding the confidentiality of medical records which ensures records are handled to preclude loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of health information • Policy should address the training/education of personnel in regards to patient confidentiality • Policy should include compliance with and adherence to Federal HIPAA privacy and security regulations • In addition, personnel must hold all information obtained about patients related to their examination, care and treatment confidential and not divulge the information without the patient’s authorization, unless such information is: • Required by law, • Necessary to coordinate the patient’s care with physicians, hospitals or other health care entities, or to coordinate insurance or other matters pertaining to payment, or • Necessary in compelling circumstances to protect the health or safety of an individual • Any release of information in response to a court order must be reported to the patient in a timely manner</td>
</tr>
</tbody>
</table>

| **B** Structural Integrity | |
| 1 Elements in the medical record are organized in a consistent manner | • Medical record is clearly organized • Records are organized in chronological order • Medical record does not contain information for other patients • If family members are in one record, each family member must be clearly separated |
| 2 Pages are secured | • All pages, reports and forms are maintained in such a way to prevent loss and misfiling |

**Critical Documentation Standards are bolded**

Date Approved: 08/11/2009
### MEDICAL RECORD SECTION – ADULT

#### 3 Demographic sheet included in medical record
- Personal demographic sheet to include the address, employer, insurer, emergency contact, marital status and home/work telephone numbers

#### 4 All pages contain patient identification
- All pages in medical record will contain at least one of the following for patient identification purposes:
  - Patient’s full name
  - Identification number

#### 5 All entries dated
- All entries, updates, and addendums in the record must be dated.

#### 6 All entries signed by author
- All entries in medical record must be signed by the author
- Author identification may be a handwritten signature, unique electronic identifier or initials
- A signature and initial log must be maintained by the office

#### 7 Entries are legible
- Entries are legible to a reader other than the author
- Content of records is presented in a standard format that allows a reader, other than the author, to review without the use of separate legend/key

### Health Maintenance

#### 1 Updated problem list is maintained
- A problem list which summarizes significant illnesses and medical/psychological conditions, including those that are chronic, is updated and maintained on the chart
- All notations on the problem list are dated

#### 2 Current medication(s) are documented and reviewed annually by practitioner
- Information regarding current medications is readily apparent
- Changes to medication regimen are noted as they occur
- Documentation of at least annual review of medications by practitioner

#### 3 Medication allergies and adverse reactions are prominently noted in the record
- Medication allergies are noted in a prominent place
- Adverse reactions (such as rash, vomiting, etc.) are also noted; history of an unknown adverse reaction should be indicated as such
- If patient has no known allergies or history of adverse reactions, there is appropriate documentation of “none” or “NKDA”
### Documentation regarding the use of tobacco, alcohol, and drug/substance abuse
- Must have documentation in the medical record regarding smoking habits, history of alcohol use and drug/substance abuse for patients 12 years of age and older
- Should be documented when patient establishes care and updated/reviewed annually
- Prevention and/or education should also be documented in the record

### History and Physical
#### 1. Past medical history is documented in medical record
- History documentation should include serious accidents, operations, illnesses, and procedures
- Self administered patient questionnaires are acceptable to obtain baseline past medical history
- There is written documentation to explain lack of information regarding history (e.g. poor historian, unwilling to provide information, etc.)
- Medical and surgical history should be updated annually

#### 2. Comprehensive physical exam every 1-2 years
- A comprehensive exam should include a review of all systems (cardiovascular, pulmonary, endocrine, gastrointestinal, HEENT, hepatobiliary, musculoskeletal, neurological) and a psychosocial assessment
- All chronic conditions should be assessed and/or addressed
- The exam should also document height, weight, BMI, and vital signs
- For patient’s age 65 and over, or those with special needs, an annual pain assessment and functional assessment should be documented as well

### Documentation For Each Visit/Encounter
#### 1. Reason for visit/chief complaint is clearly documented
- The reason for each encounter is clearly documented; may include the patients own words

#### 2. Objective findings/clinical assessment is documented
- Objective findings/clinical assessment and physical examination are documented and correspond to the patient’s chief complaint, purpose for seeking care and/or ongoing care for chronic illnesses

#### 3. Working diagnoses are documented and consistent with findings
- Working diagnoses that logically follow from the clinical assessment and physical examination are documented
- Documentation of chronic conditions are in accordance with established Clinical Practice Guidelines
|   | Plan of action/treatment is documented and consistent with diagnosis(es) | Proposed treatment plans, therapies or other regimens are documented and logically follow previously documented diagnoses  
|   |   | Rationale for treatment decisions appear medically appropriate and substantiated by documentation in the medical record  
|   |   | Laboratory and other studies are ordered as appropriate  
|   | There is no evidence patient is placed at inappropriate risk by a diagnostic or therapeutic procedure | Clear justification for diagnostic and therapeutic procedures is documented in the medical record  
|   | Unresolved problems from previous visits are addressed in subsequent visits | Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes  
|   | Follow-up instructions and time frame are documented | Specific follow-up visits/instructions should be documented and time frame should be documented in days, weeks, months, or as needed (prn)  
| F | Continuity of Care | Consultation, lab and imaging/test results reflect provider review  
|   |   | Consultation, lab and imaging/test results are initialed by the practitioner who ordered them, to signify review (review and signature by professionals other than the ordering practitioner do not meet this requirement)  
|   |   | If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner  
|   |   | Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans  
|   | Hospital discharge summaries are filed in medical record and reviewed by PCP within 30 days of discharge | Hospital discharge summaries are included as part of the medical record for all hospital admissions  
|   |   | Review of discharge summary by PCP within 30 days of discharge is documented by practitioner's initials and dated  
|   | Patient noncompliance addressed by provider | Patient noncompliance is documented  
|   |   | Continued noncompliance is readdressed periodically  
| G | Preventive Care and Counseling | Complete immunization record or documented history  
|   |   | Medical record includes documentation of immunizations administered, including flu shots  

Critical Documentation Standards are bolded  

Date Approved: 08/11/2009
## MEDICAL RECORD SECTION – ADULT

### 2. Preventive screening and services

- Medical record should include documentation that preventive services (i.e. colonoscopy, cervical cancer screening, etc) were ordered and performed
- If patient chose to defer or refused services documentation of such should be made as well
- Practitioners may document that a patient sought preventive services from another practitioner, e.g., OB/GYN

### 3. Diet and exercise with annual BMI

- Documentation of counseling relative to diet (including fat and cholesterol intake and screenings), exercise and/or activity level, and evaluation of lifestyle
- Should also include documentation of height, weight and BMI annually

### 4. Advance care planning

- For patient’s age 65 and over, or those with special needs, there is documentation in the medical record that the issue of the living will or durable power of attorney for healthcare has been discussed with the patient or that the practitioner has counseled/educated the patient on advanced care planning
- It is recommended that a copy of any advanced care directives (e.g. POA, DNRCC, etc.) be on file in the medical record

The following standard is not included in provider recredentialing scoring, however will be audited separately at the time of review:

<table>
<thead>
<tr>
<th>Reimbursement Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM and CPT codes reported on the health insurance claim form are supported by documentation on the medical record</td>
</tr>
</tbody>
</table>
# Medical Record Documentation Standards – Pediatrics

**Paramount Care, Inc. | Paramount Advantage | Paramount Care of Michigan, Inc.**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> General Requirements</td>
<td></td>
</tr>
<tr>
<td>1 Oversight of medical records system</td>
<td>• There is a designated staff person who is qualified by training or experience for the oversight of, and access to, the medical records system.</td>
</tr>
<tr>
<td>2 Medical records confidentiality policy</td>
<td>• Provider site maintains a policy regarding the confidentiality of medical records which ensures records are handled to preclude loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of health information • Policy should address the training/education of personnel in regards to patient confidentiality • Policy should include compliance with and adherence to Federal HIPAA privacy and security regulations • In addition, personnel must hold all information obtained about patients related to their examination, care and treatment confidential and not divulge the information without the patient’s authorization, unless such information is: • Required by law, • Necessary to coordinate the patient’s care with physicians, hospitals or other health care entities, or to coordinate insurance or other matters pertaining to payment, or • Necessary in compelling circumstances to protect the health or safety of an individual • Any release of information in response to a court order must be reported to the patient in a timely manner</td>
</tr>
</tbody>
</table>

<p>| <strong>B</strong> Structural Integrity | |
| 1 Elements in the medical record are organized in a consistent manner | • Medical record is clearly organized • Records are organized in chronological order • Medical record does not contain information for other patients • If family members are in one record, each family member must be clearly separated |
| 2 Pages are secured | • All pages, reports and forms are maintained in such a way to prevent loss and misfiling |</p>
<table>
<thead>
<tr>
<th>3</th>
<th>Demographic sheet included in medical record</th>
<th>• Personal demographic sheet to include the address, parent/guardian name(s), parent/guardian employer, insurer, emergency contact and parent/guardian home/work telephone numbers</th>
</tr>
</thead>
</table>
| 4 | All pages contain patient identification | • All pages in medical record will contain at least one of the following for patient identification purposes:  
  • Patient’s full name  
  • Identification number |
| 5 | All entries dated | • All entries, updates, and addendums in the record must be dated. |
| 6 | All entries signed by author | • All entries in medical record must be signed by the author  
  • Author identification may be a handwritten signature, unique electronic identifier or initials  
  • A signature and initial log must be maintained by the office |
| 7 | Entries are legible | • Entries are legible to a reader other than the author  
  • Content of records is presented in a standard format that allows a reader, other than the author, to review without the use of separate legend/key |

C  Health Maintenance

| 1 | Updated problem list is maintained | • A problem list which summarizes significant illnesses and medical/psychological conditions, including those that are chronic, is updated and maintained on the chart  
  • All notations on the problem list are dated |
|---|---|---|
| 2 | Current medication(s) are documented and reviewed annually by practitioner | • Information regarding current medications is readily apparent  
  • Changes to medication regimen are noted as they occur  
  • Documentation of at least annual review of medications by practitioner |
| 3 | Medication allergies and adverse reactions are prominently noted in the record | • Medication allergies are noted in a prominent place  
  • Adverse reactions (such as rash, vomiting, etc.) are also noted; history of an unknown adverse reaction should be indicated as such  
  • If patient has no known allergies or history of adverse reactions, there is appropriate documentation of “none” or “NKDA” |
### 4. Documentation regarding the use of tobacco, alcohol, and drug/substance abuse

- Must have documentation in the medical record regarding smoking habits, history of alcohol use and drug/substance abuse for patients 12 years of age and older
- Should be documented when patient establishes care and updated/reviewed annually
- Prevention and/or education should also be documented in the record

### D. History and Physical

#### 1. Family, pregnancy and newborn history

- Family history should document any significant and/or chronic illnesses (i.e. diabetes, cancer, etc) of patient’s immediate family members
- Pregnancy history should document significant information with regard to complications of pregnancy or illness of the mother during pregnancy, especially those with potential impact on the fetus
- Newborn history should document pertinent information with regard to the delivery itself (vaginal or Cesarean), any complications during delivery, and health of the newborn

#### 2. Past medical, surgical and immunization history

- All pertinent medical history should be documented in the medical record and will include serious accidents, operations, and illnesses
- Immunization records from prior health care providers are documented in the chart (the presence of “up to date” or “UTD” is not sufficient documentation for immunization history)
### Comprehensive Physical exam/Well Child exams

- Unclothed physical exam to include: head circumference through age 2, weight for length to 18 months, with accurate plotting of head circumference, length and height on a growth chart
- Annual height, weight and BMI calculation for ages 3-18, with accurate plotting of height and weight on a growth chart and BMI on a Body Mass Index-for-age Percentile chart (or at minimum BMI with documented percentile)
- Documentation of general appearance, head, eyes, ENT, neck, chest, lung sounds, heart sounds, abdomen, umbilicus, genitalia, hips/pelvis, extremities, neurological and skin examinations
- Documentation of Developmental Milestones, at each well exam, which are a set of functional skills or age-specific tasks that most children can do at a certain age range, including:
  - Gross motor: using large groups of muscles to sit, stand, walk, run, etc., keeping balance, and changing positions
  - Fine motor: using hands to be able to eat, draw, dress, play, write, and other such activities
  - Language: speaking, using body language and gestures, communicating, and understanding of what others say
  - Cognitive: thinking skills, including learning, understanding, problem-solving, reasoning, and remembering
  - Social: interacting with others, having relationships with family, friends, and teachers, cooperating, and responding to the feelings of others
<table>
<thead>
<tr>
<th></th>
<th>Documentation For Each Visit/Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reason for visit/chief complaint is clearly documented</td>
</tr>
<tr>
<td>2</td>
<td>Objective findings/clinical assessment is documented</td>
</tr>
<tr>
<td>3</td>
<td>Working diagnoses are documented and consistent with findings</td>
</tr>
<tr>
<td>4</td>
<td>Plan of action/treatment is documented and consistent with diagnosis(es)</td>
</tr>
<tr>
<td>5</td>
<td>There is no evidence patient is placed at inappropriate risk by a diagnostic or therapeutic procedure</td>
</tr>
</tbody>
</table>

**Vision:** Examine eyes; assess ability to fix and follow with each eye, alternate occlusion, corneal light reflex, red reflex

**Hearing:** Conduct initial hearing screening if not previously done; otherwise assess for possible hearing loss, with follow-up screening as needed or refer to a specialist for hearing screen

**Dental:** Documentation of referral to dentist annually

**Lead exposure:**
- All children should be assessed for risk of lead exposure at age one (1) and at age two (2)
- Perform a blood lead test at age one (1) and again at age two (2) for all Medicaid children and those children who live in a high risk zip code or are assessed as being high risk for exposure (i.e., lives in a house built before 1950, frequently comes in contact with an adult who works with lead, etc.); repeat testing as needed for children with high blood lead levels or who are at risk for exposure
### MEDICAL RECORD SECTION – PEDIATRICS

<p>| | | | |</p>
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<tbody>
<tr>
<td>6</td>
<td>Unresolved problems from previous visits are addressed in subsequent visits</td>
<td>• Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Follow-up instructions and time frame are documented</td>
<td>• Specific follow-up visits/instructions should be documented and time frame should be documented in days, weeks, months, or as needed (prn)</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Continuity of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Consultation, lab and imaging/test results reflect provider review</td>
<td>• Consultation, lab and imaging/test results are initialed by the practitioner who ordered them, to signify review (review and signature by professionals other than the ordering practitioner do not meet this requirement)</td>
<td>• If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner</td>
</tr>
<tr>
<td>2</td>
<td>Hospital discharge summaries are filed in medical record and reviewed by PCP within 30 days of discharge</td>
<td>• Hospital discharge summaries are included as part of the medical record for all hospital admissions</td>
<td>• Review of discharge summary by PCP within 30 days of discharge is documented by practitioner's initials and dated</td>
</tr>
<tr>
<td>3</td>
<td>Parent/Patient noncompliance addressed by provider</td>
<td>• Parent/Patient noncompliance is documented</td>
<td>• Continued noncompliance is readdressed periodically</td>
</tr>
<tr>
<td>G</td>
<td>Preventive Care and Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Complete immunization record</td>
<td>• Medical record includes documentation of immunizations administered, including flu shots</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Injury prevention</td>
<td>• Documentation of discussion regarding areas such as car seats, seat belts, smoke detectors, pools/water safety, toxic chemicals, safe drug storage, toy safety, gun safety, and other injury prevention measures</td>
<td>• Birth-18 months: focus on breast feeding, formula feeding, introduction of solid foods</td>
</tr>
<tr>
<td>3</td>
<td>Diet and exercise</td>
<td>• Ages 2-18: caloric balance, snacks, fat and cholesterol</td>
<td>• Exercise: age appropriate activities, sports and exercise</td>
</tr>
<tr>
<td>4</td>
<td>Anticipatory guidance</td>
<td>• Documentation of age appropriate counseling in healthy habits, social competence, family relationships, community interactions, school entry, responsibility, school achievement, sexual practices/precautions, and prevention/education relative to tobacco, alcohol and drug abuse (including parent education/guidance in regard to second hand smoke exposure)</td>
<td></td>
</tr>
</tbody>
</table>

Critical Documentation Standards are bolded

Date Approved: 08/11/2009
The following standard is not included in provider recredentialing scoring, however will be audited separately at the time of review:

<table>
<thead>
<tr>
<th>Reimbursement Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM and CPT codes reported on the health insurance claim form are supported by documentation on the medical record</td>
</tr>
<tr>
<td>• All ICD-9-CM and CPT codes reported on the health insurance claim form are clearly supported by documentation in the patient’s medical record</td>
</tr>
</tbody>
</table>
PARAMOUNT WEBSITE AND MyPARAMOUNT
SECTION 10.0

PARAMOUNT ADVANTAGE
Affiliate of ProMedica
The “provider” section of Paramount’s website is rich in resources to assist our providers. We encourage you to explore the website and then to visit it often for the most up-to-date provider news.
MyParamount – Paramount’s Interactive Portal

Paramount is focused on providing you with ease of communications by providing a portal that will allow you to interact and communicate with us, eliminating the need for phone calls to complete routine transactions.

• With a standard desktop computer or tablet or smartphone, and an Internet connection, provider offices can connect from anywhere, at any time, day or night.
• Our portal is fully compliant with all HIPAA privacy standards. All information and transactions are fully secure.
• The portal will not allow access to information by unauthorized users.

Features

Based on your level of access, you’ll be able to:

• View and print authorization status online
• View and print claim status and EOP
• Look up eligibility, benefit plan descriptions, copays and deductibles, and panel rosters (primary care physicians)
• Access information/conduct transactions for multiple provider offices using a single login
• Access online provider directories, maps and directions

For more information, please contact Paramount at 419-887-2855.

Some Helpful Tips When Accessing the Website

• Never share your login with another associate. If you are in need of a login, please call Paramount at 419-887-2535.
• Change your password the first time you login to the website and then periodically thereafter.
• Please notify Paramount when an associate with a login to MyParamount has been terminated so that we may remove the login.
• When searching for a claim or authorization, please enter as much information as possible to narrow down your search (i.e., member name, date of service, member number).
• All primary care physicians who have access to MyParamount should submit their referrals online to Paramount. Once a provider is trained on MyParamount, Paramount will only accept online or faxed prior authorizations.

If you are experiencing problems with the portal, please feel free to call 419-887-2535.