A New Web Site for You!

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www.paramounthealthcare.com

Paramount and ProMedica recently launched our new consumer web sites. The new sites were designed and structured around feedback from you, our partners.

After extensive research, we took a new approach to the Paramount website. The new site is organized based on your affiliation with Paramount. Are you a Member? Or a Provider? You self identify and go into the area of the site that contains your relevant information.

Additionally, we have put quick links on our homepage for items that you most frequently access. Take a look at the top of the page where you can Find a Provider, Pay Your Bill and Contact Us. Also, you can quickly log into your Provider DIRECT account by clicking on the Provider DIRECT Log In button under the Provider image.

All of these improvements were meant to make your life a little easier. We hope you enjoy the new site and find it improved. We would love to hear what you think – click on the survey link in the middle of the homepage. Be sure to come back to our site as we add more features in the near future.
Preferred Brand Drug List Changes for 2012

The Pharmacy and Therapeutics Working Group, a subgroup of the Medical Advisory Council at Paramount, has reviewed and approved changes to the Preferred Drug List.

This Preferred Drug List (PDL) only includes brand-name prescription drugs, which are available at the preferred-brand copayment level if a generic drug is not available. When a brand-name drug on this preferred list becomes generically available, the brandname drug may no longer be offered at the preferred-brand copayment level. When a generic version of reasonable price becomes available, the brand-name version becomes a multisource brand and may no longer be covered or may be available at higher copayment levels.

2012 PDL Additions:
- Osteoporosis – Atelvia®
- Autonomic & CNS medication – Methylphenidate ER®
- Anticoagulant – Pradaxa®
- Prenatal vitamin – Prefera-OB® Plus DHA
- Immunosuppressant – Gengraf®

2012 PDL Deletions with Generic Alternatives:
- Dermatological – Aldara® (generic imiquimod)
- Anti-infective – Augmentin® (generic amoxicillin and clavulanate potassium)
- Antihypertensive – Caduet® (generic amlodipine and atorvastatin)
- SNRI Antidepressant – Effexor XR® (generic venlafaxine)
- Antineoplastic – Femara® (generic letrozole)
- Dermatological – Fluoroplex® (generic topical fluorouracil)
- Antiinfective – Levaquin® (generic levofloxacin)
- Cholesterol Lowering – Lipitor® (generic atorvastatin)
- Dermatological – Loprox® (generic ciclopirox)
- Dermatological – MetroGel® (generic topical metronidazole)
- Gastrointestinal – Prilosec OTC® (generic omeprazole)
- Antiviral – Valtrex® (generic valacyclovir)
- SNRI Antidepressant – venlafaxine ER (generic venlafaxine)
- Ophthalmic – Xalatan® (generic latanoprost)
- Antiviral (dermatological) – Zovirax® (generic topical acyclovir)

Questions? Need a Full Preferred Drug List?
If you have any questions about your prescription drug benefit or would like a copy of the complete 2012 Preferred Drug List, call Member Services at 1-419-887-2525 or 1-800-462-3589. You can also visit the Paramount website at www.paramounthealthcare.com. In the “Members” section, click on “Prescription Drug Benefits,” “Preferred Drug Lists,” and “2012 Commercial Preferred Drug List.”

Over-the-Counter (OTC) Updates
Prilosec OTC, Claritin OTC, Zyrtec OTC, Allegra OTC and Prevacid 24HR continue to be covered for all Paramount Commercial members at the generic copayment level. A prescription is necessary for the pharmacy to process an approved OTC medication under your prescription benefit.
The Clinical Guidelines for Physicians can be reviewed and printed by physicians and physician offices from the Paramount website. These guidelines are evidenced-based and intended for use as a guide in caring for Paramount members. The Medical Advisory Council reviews and approves each guideline annually. The guidelines are adopted from various nationally recognized sources. The guidelines will not cover every clinical situation and are not intended to replace clinical judgement.

The following guidelines have been reviewed and approved by the Medical Advisory Council as of April 13, 2011:

- **Alcohol Guideline** - this guideline is taken from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) publication “A Clinician’s Guide: Helping Patients Who Drink Too Much”, Updated 2005 edition and the “Pocket Guide for Alcohol Screening and Brief Intervention.” There have been no changes since 2008.

- **Asthma (Adult and Pediatric)** – this guideline is based on The National Heart Lung and Blood Institute Expert Panel 3 (EPR#): Guidelines for the Diagnosis and Management of Asthma which was released in 2007.

- **CHF Guideline** - Paramount Clinical Guideline for Outpatient Management of Chronic Heart Failure algorithm based on 2009 Focused Update: ACCF/AHA guideline update from the Diagnosis and Management of Chronic Heart Failure in the Adult, the American Journal of Cardiology, August 24, 2010, represents the most current recommendations. Paul Berlacher, MD, and Ajwad Farah, PA, developed Paramount’s algorithm, a streamlined version as reference for Primary Care Providers to manage their patients with chronic heart failure.

- **COPD Guideline** - the guideline represents the latest updated recommendations from the NHLBI/ WHO - Global Initiative for Chronic Obstructive Lung Disease (GOLD), Pocket Guide To COPD Diagnosis, Management, and Prevention, A Guide for Health Care Professionals, Updated 2010.

- **Depression Guideline** – this guideline is based on the recommendation from the USPSTF for depression screening in adults, adolescents and children. There have been no changes since 2009. ProMedica Health System Depression Clinical Practice Guideline is consistent with the May 2002 recommendations and the March 2009 adolescent screening guidelines, Paramount’s utilization/case management criteria and member education materials.

- **Healthchek Guideline** - this is a special program of comprehensive health services available to the Paramount Advantage members from birth through the age of 20 years. The Ohio Department of Job and Family Services (ODJFS) developed these guidelines for the Medicaid population and expect enrollees to receive the appropriate number of well-child visits at ages and frequencies in accordance with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care periodicity schedule. No portion of the guideline can be removed; however, Managed Care Plans can add additional elements. It was noted noted the guideline states Pap Smears are recommended for all females (age eighteen or older). Sexually active adolescents should be tested regardless of age. This does not follow the ACOG Guideline which recommends cervical cancer screening should begin at age 21.

- **Hypertension Guideline** – the guideline is based on The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) released in May of 2003. The next expected update (JNC 8) is scheduled for release in the winter 2012.

- **National Cholesterol Education Program (ATP III Guidelines)** - these guidelines, published in May of 2001 and updated in July of 2004, currently represent the most up to date guidelines. The next expected update is scheduled for release in the spring of 2012.

- **Preventive Health Guideline (Pediatric)** - these guidelines are based on the American Academy of Pediatrics (AAP) 2008 Guidelines, ACOG, as well as the Advisory Committee on Immunization Practices, AAP, and the American Academy of Family Physicians approved 2011 CDC Immunization Schedule.
Paramount’s Access Standards

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

<table>
<thead>
<tr>
<th>MEDICAL / SURGICAL</th>
<th>PCP STANDARD</th>
<th>NON-PCP STANDARD</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 Recurring problems related to chronic conditions such as hypertension, asthma, and diabetes.</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 Examples include cold, sore throat, rash, muscle pain, and headache.</td>
<td>95% of members can access care within 2-4 days</td>
<td>95% of members can access care within 30 days</td>
</tr>
<tr>
<td>Urgent Medical Problems Unexpected illnesses or injuries requiring medical attention soon after they appear.</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 Life-threatening illness or injury, such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding or convulsions.</td>
<td>Immediate Care</td>
<td>Immediate Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEHAVIORAL HEALTH</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Assessments or Care for New Problems Non-urgent, non-emergent conditions, initial post-hospitalization visit, new behavioral or mental health problems.</td>
<td>95% of members are offered access to care within 14 days</td>
</tr>
<tr>
<td>Routine Follow-up Visits Continued or recurring problems when member, primary care physician and behavioral health care provider agree with or prefer the scheduled time.</td>
<td>95% of members are offered access to care within 30 days</td>
</tr>
<tr>
<td>Urgent Care Unexpected illnesses or behaviors requiring attention soon after they appear.</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 Severely limited ability to function; behavioral health care provider may either provide immediate care, or direct the patient to call 911 or be taken to nearest emergency room.</td>
<td>Immediate Care, Not to Exceed 6 hours</td>
</tr>
<tr>
<td>Life Threatening Emergency (Self or Others) The expectation is that the member will receive immediate care appropriate for the critical situation, e.g. calling 911.</td>
<td>Immediate Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE ACCESS</th>
<th>ALL PROVIDERS</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>
Paramount Member Satisfaction Results

Every year, Paramount measures members’ satisfaction with the quality of their care and services. Consumer Assessment of Healthcare Providers and Systems (CAHPS®*) surveys are conducted as part of our Healthcare Effectiveness Data and Information Set (HEDIS***) review. These surveys are important because they help us understand how we can provide you with better care and service. They also enable us to judge how we compare with health plans across the nation. Again, this year, the results were strong. When compared to the national average, Paramount scored higher in 7 of 11 measures. Paramount members rated Paramount’s customer service in the top 10 percent in the United States. Rating of getting care quickly, claims processing and rating of health plan ranked in the top 25 percent of health plans nationally. Here’s how Paramount compares to the 2011 national averages in member satisfaction for Quality Compass**.

<table>
<thead>
<tr>
<th>CAHPS® 4.0H MEASURE</th>
<th>Commercial HMO 2011 Results</th>
<th>2011 HMO National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>86.3%</td>
<td>86.2%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>89.9%</td>
<td>86.5%</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>92.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Health Plan’s Customer Service</td>
<td>90.1%</td>
<td>84.5%</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>92.2%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Rating of Health Care</td>
<td>78.4%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Rating of Health Plan</td>
<td>68.1%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>82.8%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>82.1%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

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

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
** HEDIS® and Quality Compass® are registered trademarks of the NCQA.
2010 Healthcare Effectiveness

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

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

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

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

Safeguard in Utilization

Paramount’s utilization management decisions are based only on appropriateness of care and service and the existence of coverage. Utilization management staff and associate medical/clinical directors are not financially or otherwise paid to encourage underutilization and/or denials of coverage or care. In fact, Paramount monitors and analyzes monthly reports for patterns of underutilization and takes action to address any identified problems. In addition, nursing staff cannot deny services—denials can be made only by board certified, locally participating physicians.
Below are HEDIS® results for Commercial (HMO), Paramount Elite and Paramount Advantage compared to Paramount’s 2010 goals. Measures showing statsitically significant improvement (p < 0.05) from the previous year are indicated with a †. A copy of the Quality Improvement Program Evaluation can be requested by calling 419-887-2500 or by email at phcquality@promedica.org.

<table>
<thead>
<tr>
<th>Effectiveness of Care Measure</th>
<th>Paramount HMO</th>
<th>Paramount Elite</th>
<th>Paramount Advantage</th>
<th>Paramount Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Combo 2</td>
<td>77.4%</td>
<td>Not applicable</td>
<td>62.8%</td>
<td>87%</td>
</tr>
<tr>
<td>(DTaP, OPV/IPV, MMR, Hib, Hepatitis B, VZV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer Screenings:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening (women ages 40-69)</td>
<td>70.1%</td>
<td>70.0%</td>
<td>47.5%</td>
<td>74%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (women ages 21-64)</td>
<td>79.6%</td>
<td>Not applicable</td>
<td>77.2%</td>
<td>88%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women (ages 16-24)</td>
<td>32.1%</td>
<td>Not applicable</td>
<td>50.8%</td>
<td>40%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (men &amp; women ages 50-80)</td>
<td>56.1%</td>
<td>62.8%</td>
<td>Not applicable</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Pregnancy Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of Prenatal Care (first trimester)</td>
<td>97.6% †</td>
<td>Not applicable</td>
<td>93.2% †</td>
<td>98%</td>
</tr>
<tr>
<td>Postpartum Care (at 21-56 days)</td>
<td>88.8%</td>
<td>Not applicable</td>
<td>74.7%</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Cardiovascular Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure (&lt; 140/90)</td>
<td>70.0% †</td>
<td>66.9%</td>
<td>63.9%</td>
<td>68%</td>
</tr>
<tr>
<td>Persistent Beta Blocker Treatment After a Heart Attack</td>
<td>Not reportable</td>
<td>93.9% †</td>
<td>Not reportable</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Cholesterol Management:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing (annual)</td>
<td>83.7%</td>
<td>88.6% †</td>
<td>64.2%</td>
<td>89%</td>
</tr>
<tr>
<td>Control (&lt;100 mg/dL)</td>
<td>57.9%</td>
<td>62.5% †</td>
<td>43.4% †</td>
<td>63%</td>
</tr>
<tr>
<td><strong>Comprehensive Diabetes Care:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c test (annual)</td>
<td>89.3%</td>
<td>94.2% †</td>
<td>79.5%</td>
<td>91%</td>
</tr>
<tr>
<td>HbA1c poorly controlled (&gt;9.0%) (lower rate is better)</td>
<td>22.9%</td>
<td>12.4%</td>
<td>39.0%</td>
<td>&lt;21%</td>
</tr>
<tr>
<td>HbA1c controlled (&lt;8%)</td>
<td>64.0%</td>
<td>80.8% †</td>
<td>50.8% †</td>
<td>60%</td>
</tr>
<tr>
<td>Dilated eye exam (annual)</td>
<td>63.5%</td>
<td>75.9%</td>
<td>65.8%</td>
<td>71%</td>
</tr>
<tr>
<td>Lipid test (annual)</td>
<td>82.2%</td>
<td>87.4% †</td>
<td>62.8%</td>
<td>88%</td>
</tr>
<tr>
<td>Lipid levels (&lt;100 mg/dL)</td>
<td>47.9% †</td>
<td>55.5%</td>
<td>29.8% †</td>
<td>51%</td>
</tr>
<tr>
<td>Nephropathy screening/treatment (annual)</td>
<td>81.0%</td>
<td>89.1%</td>
<td>68.3%</td>
<td>84%</td>
</tr>
<tr>
<td>Blood Pressure Control (&lt;140/90)</td>
<td>70.8%</td>
<td>68.6% †</td>
<td>71.0% †</td>
<td>72%</td>
</tr>
<tr>
<td>Good Blood Pressure Control (&lt;140/80)</td>
<td>43.3%</td>
<td>46.5% †</td>
<td>39.0% †</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Follow-Up After Hospitalization for Mental Illness:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 7 days</td>
<td>50.0%</td>
<td>28.3%</td>
<td>Not reportable</td>
<td>57%</td>
</tr>
<tr>
<td>Within 30 days</td>
<td>81.7%</td>
<td>63.0% †</td>
<td>Not reportable</td>
<td>79%</td>
</tr>
<tr>
<td><strong>Antidepressant Management:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Phase Medication Trial</td>
<td>69.7% †</td>
<td>60.9%</td>
<td>48.6%</td>
<td>65%</td>
</tr>
<tr>
<td>Effective Continued Drug Therapy</td>
<td>47.9% †</td>
<td>51.7% †</td>
<td>32.7%</td>
<td>53%</td>
</tr>
<tr>
<td><strong>Respiratory Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Appropriate Medications for Asthma (ages 5-56)</td>
<td>94.3% †</td>
<td>Not applicable</td>
<td>90.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Spirometry Testing for COPD</td>
<td>39.8%</td>
<td>40.4% †</td>
<td>54.1%</td>
<td>38%</td>
</tr>
<tr>
<td>Use of Systemic Corticosteroid for COPD</td>
<td>Not reportable</td>
<td>72.0%</td>
<td>Not reportable</td>
<td>75%</td>
</tr>
<tr>
<td>Use of Bronchodilator for COPD</td>
<td>Not reportable</td>
<td>53.3%</td>
<td>Not reportable</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Appropriate Antibiotic Treatment:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children with URI</td>
<td>82.8% †</td>
<td>Not applicable</td>
<td>79.1% †</td>
<td>83%</td>
</tr>
<tr>
<td>Adults with Bronchitis</td>
<td>21.8% †</td>
<td>Not applicable</td>
<td>19.5% †</td>
<td>25%</td>
</tr>
<tr>
<td>Strep Testing for Children with Pharyngitis</td>
<td>69.0% †</td>
<td>Not applicable</td>
<td>52.5%</td>
<td>71%</td>
</tr>
<tr>
<td>Advising Smokers To Quit (survey question/2 year average)</td>
<td>76.3% †</td>
<td>85.0% (1 year ave.)</td>
<td>64.7%</td>
<td>81%</td>
</tr>
</tbody>
</table>
How do you determine if a child is at risk for lead poisoning?

There are 3 ways to determine if a child is at risk. Ohio State Law Substitute House Bill 248 requires that:
1) All Medicaid & Healthy Families and all Healthy Start Consumers (regardless of zip code or exposure to lead) receive a blood lead test at age one and again at age two.
2) All children residing in a High Risk Zip Code area receive a blood lead test at age one and again at age two.
3) A Risk Assessment Questionnaire must be used for all other children (Low Risk Zip Codes) in this age category. For a list of risk assessment questions, follow the directions below. A blood lead test must be completed if the answer is yes or unknown to any of the questions.

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

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

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

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

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

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

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

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

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

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

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

Coding correctly is very important to capture a Healthchek exam. For a list of billing codes, please refer to the Healthchek Coding Guide on the website.
The Centers for Medicare and Medicaid Services (CMS) Quality Star Ratings System

Background
On an annual basis, the Centers for Medicare and Medicaid Services (CMS) rates Medicare Advantage (MA) Plans on a 1 to 5 star scale, with 5 stars representing the highest quality plans. The summary score provides an overall measure of a plan’s quality and is a cumulative indicator of quality of care, access to care, plan responsiveness, and beneficiary satisfaction provided by the plan. These ratings are communicated to plans every October and published in the annual “Medicare & You Handbook” and posted on the Medicare.gov website each fall to assist beneficiaries in their enrollment choice. Lastly, Health Care Reform Legislation allows CMS to use quality ratings to identify and reward high performing and compliant plans in the Medicare Advantage contracts.

2012 Quality Bonus Payments
In early 2010, Health Care Reform mandated that Medicare Advantage plans achieve a minimum rating of 4 out of 5 stars to qualify for the CMS Quality Bonus Payment and rebates in the 2014 plan year. In December 2010, CMS announced that it was conducting a national 3-year demonstration project (2012 – 2014) to test whether scaled bonuses to MA plans with 3 or more stars improved plan quality at a faster rate than the previously proposed model. This means that beginning in 2012, the Quality Bonus payment will directly affect the monthly payment amount plans receive from CMS. Paramount achieved a 3.5 star rating for its Medicare Advantage-Prescription Drug (MA-PD) and Prescription Drug Plan (PDP) plans and a 4.0 star rating for its MA only plan. Under the demonstration program, Paramount would qualify for a 3.5% quality bonus in 2012 since a large majority of our members and reimbursement is located in the MA-PD plan.

In 2011, only three plans in the nation received a 5 star rating with none being in Ohio or Michigan. According to the Kaiser Family Foundation, approximately 23% of MA enrollees are in 4 or 5 star plans. The national average rating for plans, weighted by 2009 enrollment, is 3.27 stars.

Star Ratings and Measures
CMS’ star rating system considers 53 quality measures, 36 in Part C (medical) and 17 in Part D (drug), which are derived from 5 different rating systems: HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer

IMPORTANT CHANGE for PARAMOUNT ADVANTAGE MEMBERS

Effective October 1, 2011, Paramount Advantage members must use pharmacies in the Paramount network to fill prescription drugs and obtain medical supplies. Drug coverage benefits will once again be administered by Paramount.

Visit our website at http://www.paramounthealthcare.com selecting Providers then Prescription Drug Benefits to locate the Advantage Drug Prior Authorization List. The Advantage Preferred Drug List is also available within this website. Forms to request prior authorization may also be found on the provider page of our website.

For Questions, call Provider Inquiry at: (419) 887-2564 or 1-888-891-2564.
Assessment of Healthcare Providers and Systems), CMS (Centers for Medicare and Medicaid Services), HOS (Health Outcomes Survey), and IRE (Independent Review Entity). The star ratings are currently based on criteria that show how well the plan performs in a number of categories, including:

**Part C**
- Staying healthy via preventive services such as screenings and vaccines;
- Managing chronic conditions;
- Ratings of plan responsiveness and care;
- Complaints, appeals, and voluntary disenrollment; and
- Telephone customer service including member satisfaction, customer service and responsiveness

**Part D**
- Drug Plan Customer Service
- Drug Plan Member Complaints and Medicare Audit Findings
- Member Experience with Drug Plan
- Drug Pricing and Patient Safety

**2012 and Beyond**
CMS significantly updated the star ratings measures and methodology for 2012, including adding nine new measures and retiring nine measures. The new 2012 measures include all-cause readmissions, adult Body Mass Index (BMI), medication adherence and enrollment/enrollment rates. Further, starting in 2012, each of the measures are weighted which will translate into the overall health plan ratings. Measures that look at outcomes and intermediate outcomes are weighted three times as much as plan process measures. CMS has indicated that they plan to update the star ratings measures and methodology on an annual basis. CMS’ proposed strategy for the next several years includes measures related to participating hospital care coordination, preventable admissions and case mix adjusted mortality rates. Paramount’s focus in working with HEDIS, CAHPS, and HOS data will need to be more aggressive, especially in developing action plans to drive improved star rating results.

**Paramount Action Plan**
Paramount has completed a thorough analysis of all the individual elements that comprise our score for both the Part C and Part D components of the rating. The analysis included trending of our individual scores since star ratings began, review of competitor’s ratings, and development of an action plan to address the lowest scores and movement to higher tiers. Several actions for improvement are currently underway. This includes 2012 formulary changes that address high-risk medication use by removing certain drugs, prior authorization edits and adding preferred brand status to safe drug alternatives. An upgrade to the TTY/TDD telecommunications devices for the deaf was implemented in May 2011 in order to provide consistent and reliable service to our customers. Future action plans include implementation of a provider focused education program, which will include one to one provider education on the star measures and best practices. Member education and alerts, such as letters and telephone contacts, will also be important with improving member awareness and compliance with preventative services and the management of chronic conditions. Paramount recognizes that the star ratings program will be an ongoing, collaborative effort involving providers, members and staff with the ultimate goal to improve overall quality of care and member satisfaction.

For more information about the CMS Star Ratings Program and Paramount ratings data, contact Nicole Stenberg, Elite Risk Adjustment Manager, at 419-887-2215.
Respiratory Syncytial Virus

Now that Respiratory Syncytial Virus (RSV) season is upon us, Paramount would like to make you aware of important information to help you maintain the health and well-being of your patients. Paramount Health Care will continue to follow the guidelines for Synagis® set forth by The American Academy of Pediatrics (AAP). The primary care physician, pediatrician, pulmonologist or cardiologist involved in the infant’s care may order the Synagis® series. The injections may be given by an approved Paramount home health care agency or administered in the physician’s office. Benefit limits, co-insurance and copayments may apply.

We will continue to follow the AAP guidelines for infants born between 32 weeks, 0 days through 34 weeks, 6 days that meet the following criteria:

- Must be younger than 3 months of age at the start of the RSV season or born during the RSV season; and
- Must either attend child care or have a sibling younger than 5 years of age.
- Synagis® should only be given until the infant reaches 3 months of age.

When Synagis® is to be provided in the home, please fax the attached Synagis® authorization form to your Paramount home care provider to be screened. The criteria will be reviewed by the home health care agency for appropriateness. The home health care agency will fax the completed form to Paramount for prior authorization.

If Synagis® is to be provided in a physician’s office, please fax directly to Paramount Health Care at 419-887-2028 for prior authorization of the medication.

Paramount Health Care will utilize the Toledo Hospital Outpatient Pharmacy/The Pharmacy Counter and Curascript to supply Synagis® for the 2011-2012 RSV season.

If you have questions, please contact Kathy Steffen, Utilization Management Pharmacy Coordinator, at 419-887-2245.
SYNAGIS® Prior Authorization
Worksheet/Prescription Order Form.
Please FAX this completed form to
the appropriate in plan home care agency.
Please note home care requires prior auth.

Patient Information (Bold items are required)

Patient’s (Child’s) Name: ____________________________  □ M  □ F  DOB: ____________

Gestational Age (GA) _____ Weeks _____ Days  Birth Weight _____ lb/kg  Current Weight _____ lb/kg  Date: ____________

Patient’s Address: ____________________________  Daytime Phone: (_______)
City/State/Zip: ____________________________  Evening Phone: (_______)

Parent’s Name: ____________________________  Cell Phone: (_______)  Best Time to Call: ____________
Member I.D. Number: ____________________________  Other Insurance: ____________________________

Synagis criteria are based on 2009 American Academy of Pediatrics Red Book Guidelines.

Medical Authorization Clinical Criteria (Please check ALL that apply.)

Infant/Child’s Condition

☐ ≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
☐ 29 0/7 – 31 6/7 weeks GA (≤ 6 months of age at start of season) [5 dose max]
☐ 32 0/7 - 34 6/7 weeks GA (<3 months of age at start of RSV season); check all risk factors that apply [3 dose max up to age 90 days]
☐ Other - Explain:

Risk Factors Consideration

☐ Siblings ≤ 5 years of age
☐ On O2/Airway Support
☐ Child Care Attendance
☐ Day Care Name/Ph#: ____________________________

Diagnosis for Consideration (Please Check ALL that apply.)

☐ Immunosuppressive/autoimmune disease  ☐ Severe Neuromuscular Disease  ☐ Other
☐ Congenital Abnormalities of Airways

Other - Explain:

Please note: Risk Factors for Consideration are subject to clinical and medical review

770.7

(please document treatment and attach supporting documentation)

745–747

Chronic Lung Disease/BPD: Infants and children ≤ 24 months with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season.

Diagnosis:

Treatment:

☐ Mechanical ventilation: yes / no  Days/Duration ____________
☐ Suplemental oxygen: yes / no  Days/Duration ____________
☐ Steroids and/or diuretics: yes / no  Days/Duration ____________
☐ Other: yes / no  Days/Duration ____________

Cardiac (CHD) – Hemodynamically Significant: Infants and children ≤ 24 months with hemodynamically significant cyanotic & acyanotic heart disease

with moderate to severe pulmonary hypertension -747.83 or ______

with cyanotic congenital heart disease -746.9 or ______

who are receiving medication to control congestive heart failure -779.89 ______  List medications:

Other ____________________________  Dx ICD-9 ____________

Comments: ______________________________________________________________________________________

Prescriber Information (Required)

Prescriber’s Name: ____________________________  Medicaid TIN #: ____________________________  DEA#: ____________________________
Practice Name: ____________________________  NPI: ____________________________
Address: ____________________________  City: ____________________________  State: ____________________________  Zip: ____________________________
Phone: ____________________________  Fax: ____________________________  Synagis Contact: ____________________________

Rx Information  Special Instructions:

☐ Synagis® (palivizumab) 50 mg and/or 100 mg vials  Sig: Inject 15 mg/kg IM one time per month _______ # Doses

Date for first Injection: ____________  Delivery to:  □ Patient’s Home  □ MD Office

Prescriber’s Signature: ____________________________  Date: ____________

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.
Covered Families and Children Medicaid Consumers, including Healthy Start/Healthy Families Members’ Rights & Responsibilities

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

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

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

1. Persons eligible for Covered Families and Children Medicaid consumers, including Healthy Start/Healthy Families have the right to select a HIC qualified to serve Medicaid recipients in their county of residence.
2. Membership is mandatory in all eighteen counties in the NW Region. As of June 1, 2006, pending and new members will no longer have the right to request continuity of care deferments due to ODJFS specified prescheduled health services. Such members having prescheduled services with a non-contracted provider must contact PA in advance of the service date to coordinate services and agreed upon reimbursement. Additionally, an eligible individual may request exclusion from membership when as a result of a special health care condition and/or circumstances as determined by ODJFS. Membership will not affect eligibility for Covered Families and Children Medicaid consumers, including Healthy Start/Healthy Families-related benefits. A HIC cannot refuse members based upon their race, creed, color, religion, sex, sexual orientation, age, disability, national origin, Vietnam-era veteran’s status or other veteran status, place of residence, source of payment or credit history, ancestry, health status or need for health services.
3. A member in a HIC has the right to contact the Ohio Department of Job and Family Services (ODJFS) managed Care Enrollment Center (1-800-605-3040, TTY1-800-292-3572), to transfer to another HIC, request a just cause disenrollment or to return to fee-for-service Medicaid if they meet ODJFS’ requirements for Optional MCP Enrollment. Persons must choose another HIC at the time of termination. Terminations will be effective no later than the first day of the second month following the date upon which a termination form is completed.
4. Terminations may only be processed during the first three months of membership, or during the annual open selection month for the NW Region or with “just cause” reason as determined by the ODJFS. It is the member’s responsibility to contact the Bureau of Managed Health Care ODJFS at 50 West Town Street, Suite 400, Columbus, OH 43215, 614-466-4693 or the Managed Care Enrollment Center, if an application for “just cause” reason to terminate is desired. “Just cause” reason shall be granted, in writing, only by ODJFS.
5. No members will be forced to terminate by the HIC because of their health status or need for health services.
6. Members in a HIC have the right to receive, at a minimum, the same services they would receive under Medicaid, provided that they receive all medical services, except emergency services, in or through HIC facilities or providers.
7. Members in a HIC have the right to receive preventive health care education services under the direction of a provider including, for persons under age twenty-one (21), HEALTHCHEK services.
8. Members in a HIC have the right to file a grievance or appeal and receive an answer regarding the policies, personnel or practices of a HIC. HIC members also have the right to submit grievances or decisions with which they disagree, to the Director of the Ohio Department of Insurance and the Ohio Department of Job and Family Services.
9. Members in a HIC have the right to quality services, appropriate to their health care needs, which are delivered in a timely manner.
MEMBERS HAVE THE RIGHT TO:
- to receive all services that Paramount Advantage must provide.
- be treated with respect and with regard, for their dignity and privacy.
- be sure that their medical record information will be kept private.
- be given information about their health. Such information may also be available to someone who they have legally authorized to have the information or whom they said should be reached in an emergency when it is not in the best interest of their health to give it to them.
- be able to take part in decisions about their health care unless it is not in their best interest.
- get information on any medical care treatment, given in a way that they can follow.
- be sure that others cannot hear or see them when they are getting medical care.
- be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- ask, and get, a copy of their medical records, and to be able to ask that their record be changed/corrected if needed.
- be able to say yes or no to having any information about them given out unless Paramount Advantage has to by law.
- be able to say no to treatment or therapy. If they say no, the doctor or Paramount Advantage must talk to them about what could happen, and they must put a note in their medical record about it.
- be able to file an appeal, a grievance (complaint) or state hearing about Paramount Advantage, the doctors or the care they received.
- be able to get all written member information from Paramount Advantage:
  - at no cost to the member;
  - in the prevalent non-English languages of members in the Paramount Advantage service area;
  - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
  - be able to get help free of charge from Paramount Advantage and its providers if they do not speak English or need help in understanding information.
- be able to get help with sign language if they are hearing impaired.
- be told if the health care provider is a student and to be able to refuse his/her care.
- be told of any experimental care and to be able to refuse to be part of the care.
- make advance directives (a living will).
- file any complaint about not following their advance directive with the Ohio Department of Health.
- change their Primary Care Provider (PCP) to another PCP on Paramount Advantage’s panel at least monthly. Paramount Advantage must send them something in writing that says who the new PCP is and the date the change began.
- be free to carry out their rights and know that Paramount Advantage and its participating providers or ODJFS will not hold this against them.
- know that the Paramount Advantage must follow all federal and state laws, and other laws about privacy that apply.

FDA Initiative for Office and Hospital Surgical Sites

The FDA and its partners have launched an initiative to increase awareness of factors that contribute to surgical fires. As you know, not all surgeries are performed in hospitals, so practitioners who perform even minor surgical procedures in their office or clinic are advised to review the initiative. The goal is to disseminate surgical fire prevention tools, and to promote the adoption of risk reduction practices throughout the health care community. For more information on the initiative, please visit www.fda.gov/preventingsurgicalfires.
Covered Families and Children Medicaid Consumers continued

- choose the provider that gives you care whenever possible and appropriate.
- If they are female, be able to go to a woman’s health provider on Paramount Advantage’s panel for covered women’s health services.
- be able to get a second opinion from a qualified provider on the Paramount Advantage panel. If a qualified provider is not able to see them Paramount Advantage must set up a visit with a provider not on the panel.
- get information about Paramount Advantage from Paramount Health Care.
- to contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran’s status, ancestry, health status or need for health services.

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

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 East Broad Street, 37th Floor
Columbus, Ohio 43215
614-644-2703
1-866-227-6353
TTY: 1-866-221-6700

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

- provide, to the extent possible, information that Paramount Advantage and the participating providers need to care for them. Help their PCP fill out current medical records by providing current prescriptions and their previous medical records.
- engage in a healthy lifestyle, become involved in their health care and follow the plans and instructions for the care that they have agreed upon with their PCP or specialists.
- treat their Primary Care Provider (PCP) with respect and dignity.
- inform their PCP of any symptoms and problems and to ask questions.
- obtain information and consider the information about any treatment or procedure before it is done. Discuss any problems in following the recommended treatment with your PCP.
- respect the privacy of other patients in the office.
- obtain pre-authorization from their PCP, or the doctor or facility taking their calls, before seeing a consultant/specialist. The only times they do not need to contact their PCP to see a consultant/specialist are for appointments with obstetricians, gynecologists, certified nurse practitioners, certified nurse-midwives, qualified family planning providers, ODADAS and community mental health Medicaid providers, federally qualified health center providers and vision and dental providers (routine care only).
- continue seeing their previous PCP until the transfer takes effect.
- continue following Paramount Advantage policies and procedures until disenrollment takes effect.
- schedule and keep appointments and be on time. Always call if they need to cancel an appointment or if they will be late.
- learn and follow policies and procedures as outlined in the handbook.
- indicate to their doctor who they wish to designate to receive information regarding their health.
- obtain medical services from their PCP.
- treat their PCP and his or her staff in a polite and courteous manner.
- become involved in their health care and cooperate with your PCP regarding recommended treatment.
- carry their ID card at all times and report any lost or stolen cards to Paramount Advantage immediately. Also, contact Paramount Advantage if any information on the card is incorrect, or if there are changes in name, address or eligibility.
- inform Paramount Advantage of any dependent that is to be added or removed from coverage.
- notify their PCP as soon as possible if they have received emergency treatment with forty-eight (48) hours.

Clinical Guidelines continued from page 3 ....

- **Preventive Health Guideline (Adult)** - these guidelines are based on the USPSTF website at AHRQ Home/Clinical Information/U.S. Preventive Task Force recommendations and the ACOG guidelines.
- **Preventive Health Guideline (Senior Adult)** - these guidelines are based on the USPSTF recommendations. The Task Force recommended the Agency for Healthcare Research and Quality (AHRQ) designate older adults as a priority population and undertake a major initiative to improve the health and health care of older Americans.
- **Prenatal Postpartum Care Guideline** - this guideline is based on the “Guidelines for Perinatal Care” Sixth Edition, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.
- **Tobacco Cessation Guideline** – this guideline is based on the United States Preventive Task Force (USPSTF) Smoking Cessation Clinical Practice Guideline updated last in April 2009.

To view the guidelines go to www.paramountheallthcare.com, click on “Provider”, then click on “Publications and Resources, then “Clinical Practice Guidelines”. 
Medicare Member Rights and Responsibilities

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

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

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

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

HOW PREPARED ARE YOU FOR ICD-10 TRAINING?

As the U.S. prepares for ICD-10, Owens Community College is committed to supporting today’s medical coders with tools for making the transition.

Now available: a two-part online assessment tool that will help you quickly determine how prepared you are for ICD-10 training.

The assessments test your current knowledge of Anatomy, Physiology, Pathophysiology and Language of Medicine.

After completion of the assessments, you will be given a recommendation about whether you should consider taking online classes to brush up on any of these areas before pursuing ICD-10 training.

The fee for the assessments is $50 per person. You can only take the assessment once, but the fee covers both assessments:
1. Language of Medicine, Pathophysiology
2. Anatomy and Physiology

To register to take the assessments, call (567) 661-7357 or sign up online at https://www.owens.edu/workforce_cs/ICD10.
Commercial Member Rights and Responsibilities - Ohio & Michigan

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

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

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

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

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

Patient Rights and Responsibilities
Michigan law sets forth the following rights and responsibilities for health care patients:
1. A patient or resident is responsible for following the health facility rules and regulations affecting patient or resident care and conduct.
2. A patient or resident is responsible for providing a complete and accurate medical history.
3. A patient or resident is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do.
4. A patient or resident is responsible for following the recommendations and advice prescribed in a course of treatment by the physician.
5. A patient or resident is responsible for providing information about unexpected complications that arise in an expected course of treatment.
6. A patient or resident is responsible for being considerate of the rights of other patients or residents and health facility personnel and property.
7. A patient or resident is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations.
ADHD/ADD Medication Follow-Up

This past year, during the HEDIS 2012 Medical Record Review, Paramount found medical records of our young members that did not have the appropriate documentation for the ADHD/ADD medication follow-up measures. Below is the measure and the three items HEDIS is looking for:

**Measure.** The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

**Initiation Phase.** The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

**Continuation and Maintenance (C&M) Phase.** The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.