THANK YOU to all the Paramount providers and staff who graciously assisted us with our 2011 HEDIS® medical record reviews. Your help was greatly appreciated!

HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Paramount’s Nurse 411
Get the 411. Answers to your medical questions are just a phone call away.

1-877-336-1616 or e-mail Nurse411@ProMedica.org
for non-emergency situations only

What is Paramount’s Nurse 411?
Paramount’s Nurse 411 is a telephonic information service for all product lines. It’s available toll-free, 24 hours every day and is staffed with a team of experienced registered nurses to provide information, education and support for health-related questions or concerns.

How does the Paramount Nurse 411 telephone program work?
It’s simple and easy:

Call the toll-free number on the back of the Paramount ID Card. The registered nurses are ready to listen to concerns and answer questions. You may also email at Nurse411@ProMedica.org. We will respond to your request within 24 hours.

When can I call Nurse 411 line?
The nurse line is available 24 hours a day, seven days a week.

How can the Nurse 411 line help me?

When healthy - The Nurse 411 line can provide general information about health, wellness and preventive care.

When sick - The Nurse 411 line can provide general information about illness, prescribed medications, upcoming tests or procedures and even surgery.

Before going to the doctor - The Nurse 411 line can help you in preparing a list of questions.

The nurse line can help members decide if they should go to an urgent care center, make a doctor’s appointment or use self-care. Paramount’s Nurse 411 is for non-emergency situations.

Call Paramount’s Nurse 411 at 1-877-336-1616
or you can e-mail Nurse411@ProMedica.org
and a nurse will respond to your question within 24 hours

Want more information, visit us online at www.paramounthealthcare.com/Nurse411
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 such as the American Diabetes Association; the American Academy of Family Practice; the American Academy of Pediatrics and the National Heart, Lung and Blood Institute. 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 12, 2011:

- **Congestive Heart Failure Guideline** - this guideline is taken from the American College of Cardiology, 2009. Srini Hejeebu, DO and Paul Berlacher, MD, cardiologist, have reviewed and approved the algorithm content. Dr. Berlacher has provided his suggestions on reformatting the algorithm to make it more user friendly. The guideline in the new format will be brought back to the Council.

- **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 later in 2011.

- **The American Diabetes Association Position Statement: Standards of Medical Care in Diabetes-2011.** Please note that the Prevention or Delay of Type 2 Diabetes, last published in 2004 by the American Diabetes Association and National Institute of Diabetes and Digestive and Kidney Diseases, has been incorporated into Standards of Medical Care in Diabetes-2011, section IV, starting on page S16.

- **Immunization Guideline** - This guideline is taken from the Centers for Disease and Prevention Control 2011 Recommended Immunization Schedule and approved by The Advisory Committee of Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

You may locate all Paramount’s current Clinical Guidelines at [www.paramounthealthcare.com](http://www.paramounthealthcare.com), Provider Information > Clinical Practice Guidelines as seen below:
2010 Paramount Elite Risk Adjustment
Medical Record Review

You and your staff may have participated in a medical record review for your Paramount Elite members in 2010. Annually, Medicare Advantage (MA) plans such as Paramount Elite review medical records in order to validate data for risk adjustment. Paramount Elite is partially funded by the Centers for Medicare and Medicaid Services (CMS) based upon claim diagnoses submitted for our members. These claims are then sent to CMS for the plan payment. Funding for the risk adjustment portion of the payment is determined by the individual member’s demographic profile (e.g. age, gender) and diagnoses. Diagnoses need to be submitted annually as they do not carry over year to year.

Our goal is to compare face-to-face visit documentation against diagnoses submitted on claims in order to verify accuracy and identify additional diagnoses not submitted on a claim. Medicare Advantage plans also review physician records to submit additional diagnosis codes that were not submitted on the claims, but were documented and supported in the face-to-face note. Other criteria are evaluated in order to meet CMS documentation requirements.

- The following documentation is reviewed:
  - Progress notes from the face-to-face office visits
  - Consult letters from the face-to-face specialist visits
  - Progress notes and consults must include all of the following to meet requirements:
    - Date of service (front and back if two-sided)
    - Identity of the member (front and back if two-sided)
    - Sufficient documentation that names and supports the diagnoses submitted on the claim
    - Physician signature

The Paramount Elite Risk Adjustment team would like to thank you for your participation and greatly appreciate your cooperation and assistance with this project. If you would like additional information or have any questions, please contact our Elite Risk Adjustment Team.

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Problem Lists for Risk Adjustment

Guidance for Problem Lists

Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports.

For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

2007/08 Risk Adjustment User Group

3. Q: Is an undated/unsigned problem list acceptable documentation of a diagnosis if the progress notes refer to the list in the medical record?
A: Plans should use the progress notes as documentation to support the diagnosis instead of the problem list. Problem lists can include any and every type of condition for a person regardless of whether the beneficiary received services for the conditions during the data collection period, and are not acceptable stand-alone documentation.
The Centers for Medicare and Medicaid Services (CMS) Documentation Requirements

- **Dated**: Date of service on each page
- **Identified**: Patient name on each page
- **Concise**: Reason for the face-to-face visit
- **Consistent**: Services rendered
- **Complete**: Conclusions, diagnoses, and follow-up
- **Logical**: Assignment of ICD-9-CM codes based on clear and legible clinical documentation
- **Authenticated**: By the provider of service (see next page)
The Centers for Medicare and Medicaid Services (CMS) Signature Requirements

In order to validate the services rendered, the patient’s medical record must clearly identify the individual who ordered/provided services. The accuracy and completeness of the documentation must be reviewed and authenticated by the treating/ordering provider.

Each entry’s signature must be legible and include the provider’s first and last name along with their applicable credentials, e.g. P.A., N.P., D.O., or M.D.

To comply with CMS signature requirements, progress notes should be on a document identifying each physician in the practice and their credentials.

Acceptable Handwritten Physician Signatures:

Mary C. Smith, MD
M. Smith, MD

Acceptable Electronic Physician Signatures:
Approved by Mary C. Smith, MD
Authenticated by Mary C., Smith, MD
Electronically Signed by Mary C. Smith, MD
Signed by Mary C. Smith, MD
Quality of Care in 2010

In April, the Medical Advisory Council (MAC) assessed the quality of care (QOC) delivered to Paramount members during 2010. Among the information reviewed were member complaints about clinical issues. After investigation by medical directors, 56% of these reports were found to involve adverse events, unplanned readmissions, medical misadventures, or other quality of care issues. Most remaining complaints stemmed from less than adequate communication.

Consistent with past years, invasive procedures were the most frequently reported cases for investigation. Nearly 75% of the QOC complaints involving inpatient readmission were due to infection following a health care encounter, up from 61% in 2009. Further analysis of all 30-day readmissions is in progress due to regulatory implications for Paramount and providers. Obstetrics/Gynecology was the specialty most commonly investigated for QOC in 2010, mostly signaled by readmission for post-operative infection. Other prominent reasons for inpatient readmission identified during QOC investigation were DVT and intestinal obstruction. A new finding from 2010 QOC reports was that 8 outpatient procedures resulted in unplanned inpatient admissions. Corrective action plans (CAP) were completed by 7 providers in 2010. On a favorable note, for the first time in many years, there were no QOC reports of injury from falls in a health care setting.

The MAC approved three opportunities for improvement:
1) Affirm members’ right to report QOC concerns by taking advantage of Paramount’s website upgrade to make the process more accessible.
2) Clarify the process for peer follow-up on CAPs, and review tracking threshold and duration.
3) Continue to collaborate with providers to promote delivery of high quality health care and reduce risk. Focus will be on reducing preventable readmissions, ensuring that members (or their representatives) receive and understand information shared with them during transitions in care (also known as “hand offs”), and developing a routine, non-punitive procedure to capture adverse event data on Paramount members from non-ProMedica hospitals.
2010 Office Manager Satisfaction Survey Highlights

Paramount conducted the 2010 Office Manager Satisfaction Survey during the month of October with 22% of office managers participating. THANK YOU to all office managers who took time away from their busy schedules to complete the survey. The majority of surveys were completed online. This important research provides valuable feedback which Paramount utilizes to improve processes and promote quality.

We would like to share highlights of the survey results:

• Office Managers continue to be highly satisfied with Paramount with nearly 90% overall satisfaction. This score is improved over the 2008 survey.

• More than 60% of Office Managers indicate that the ease of administering Paramount is about the same as other plans. Less than 10% indicate that Paramount is more difficult to administer.

• Provider Relations Representatives are highly rated with more than 90% of Office Managers being satisfied with both the service they receive and the response time after leaving a message.

• The Provider Inquiry Call Center continues to be highly utilized and Office Managers are pleased with the service they receive. The knowledge, accessibility, skill and access to resources necessary to resolve problems were all rated at 90% satisfaction for the Call Center.

• 75% of office managers are aware of Paramount’s chronic disease management programs with the majority indicating that the programs have been helpful.

• More than 90% agree Paramount’s prior authorization process is equal to or better than other insurance plans.

• Although awareness of the Case Management Program declined compared to 2008, very few problems were experienced with those who worked with a case manager.

• Ratings for all claims reimbursement measures show signs of improvement, with ratings for timeliness of claims payments increasing significantly.

• Office managers prefer communicating by phone (44.9%), followed by email (23.5%) and fax (20.7%), and last by mail (10.5%).

CONGRATULATIONS to Michael Cooper of Jack Kahns, Westgate Vision Center who was the winner of the $100 Target Gift Card. All office managers who completed the survey by October 18th were eligible for the drawing.
Everything You Need to Know about Healthchek-EPSDT

Ohio’s Medicaid Care Coordination plans are offering an in-depth seminar that gives you the information you need to meet state requirements and provide the best possible Healthchek- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services for children. The seminars are offered online and will help providers understand what services are required and when to provide the services.

Who Should Attend:
All health care provider staff.

Continuing Education Units:
This offering has been approved by the Ohio Board of Nursing (OBN) through the OBN Approver Unit at Upper Valley Medical Center OBN-005-92.

How to Participate:

2. Follow the dial in instructions
3. The schedule below includes the audio only instructions for each webinar

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<tr>
<th>Date</th>
<th>Time</th>
<th>Meeting Access Code</th>
<th>MCP Host Name</th>
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<td>963 844 971</td>
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By now, your practice has assessed your readiness for ICD-10 implementation, and probably prepared a plan. If you haven’t, the rest of this article may not make much sense. Please, jump on the bandwagon now since it will crest the hill at the end of this year and gain speed on the way down. Even though October 2013 seems like a long time off, we all know how “technological time” progresses exponentially, not linearly.

A recent article in For The Record (L Getz, May 23, 2011) proposed “ICD-10: Two Questions to Ponder”. The first question is about vendor readiness. Getz points out that many vendor contracts do not address ICD-10, even if there is a section on compliance. Whether this vendor is strictly a software supplier, a clearinghouse, or a full service billing organization, be sure you have agreement about who will do what, and when it will be tested and completed. For example, the first National Version 5010 Testing Day has already passed, and maybe the second one (8/24/2011) by the time you read this article. Did your vendor(s) participate?

The second topic Getz advises us to ponder is the cost for ICD-10 transition. “Unfortunately for providers, there is no simple formula for predicting ICD-10’s financial burden. Nevertheless, there are areas where organizations can focus to gain insight into the final price tag.” This is perhaps a textbook example of economy of scale - small practices with just a few payers can probably get away with minimal investment. For large, integrated groups and facilities, budgeting should have started years ago. Major expenses include software and its implementation, and staff training.

CMS suggests these additional considerations at http://www.cms.gov/ICD10/05a_ProviderResources.asp.

- Talk with payers about how ICD-10 might affect your agreements.
- Identify possible changes to work flow, documentation, and business processes; e.g. changing your superbill, hiring temporary staff.
- Download fact sheets and other materials from the CMS website. While there, access internal CMS links and related links to outside provider associations.

Local ICD-10 Training

Paramount is collaborating with Owens Community College and others across the region to provide ICD-10 training for professional coders, practitioners, non-credentialed office personnel, Paramount staff members, and others in the health care industry.

The community team is currently testing an ICD-10 readiness assessment. Since ICD-10 is much more detailed and precise in the way it codes diagnoses and procedures, this on-line tool will help people in jobs that depend on codes to decide if they will need a short refresher class in medical terminology, or anatomy and physiology. These refresher classes will be conducted during 2012, with the expectation of offering them online, in the workplace, and at Owens locations.

ICD-10 training will begin in early 2013 - 6 months before implementation, with an intense AHIMA-approved version for credentialed coders and an abbreviated version for everyone else. Pricing has not yet been set, but the work group’s goal has been to offer this critical education as a high quality, low cost, locally available community service.

Watch for a fax or letter from Paramount as details become available.
Coordination of Care

As you know, the requirement for in-Plan specialist referrals was eliminated January 1, 2011. Since our members have open access to plan specialists, it makes it even more important for the Specialty Care Providers to coordinate patient care with the Primary Care Providers.

Paramount has been monitoring communication from specialists to PCPs for some time. An initial survey was mailed to all PCPs early in 2010 asking whether communication from different specialty types was satisfactory. At that time, referrals were still required. Survey results indicated that physicians in most clinical specialties provide patient care feedback to PCPs most of the time. Exceptions to these generally favorable results were found in Behavioral Health and Obstetrics/Gynecology. In December of 2010, Feedback Forms were developed and provided to practitioners in these two (2) clinical areas along with letters urging them to implement some means of routine feedback. All specialty providers were reminded of the importance to communicate findings to the PCP, especially in light of elimination of referrals in 2011.

In June of this year, a re-survey was sent to all PCPs to determine if the elimination of referrals has had a negative impact on feedback/communication between providers. Preliminary results show that 85% of PCPs receive communication from specialists as often as they did when referrals were still required. Data will continue to be analyzed and interventions will be developed/distributed as necessary to continue to promote coordination of care for Paramount members. Further information will follow in future newsletters.

Paramount is once again asking providers of all specialty types to communicate findings with the PCP. Paramount will continue to monitor this issue to assure continuity of care for our members.