PROVIDER NOTICE

April 1, 2020

Implementation of New Claims Processes
Effective June 1, 2020

Claims Editing Process Changes

- On June 1, 2020, PARAMOUNT will implement new institutional claims editing processes. We are enhancing our existing, internally developed claims editing processes, which are used to administer reimbursement policy and claims edit rules. Institutional claims will now be passed through the Optum Claims Edit System® (CES), which relies on the following sources for its edits:
  - National Correct Coding Initiative (NCCI) edits, including Medically Unlikely Edits (MUEs)
  - Federal Register (the Daily Journal of the US Government that contains agency rules, proposed rules and public notices)
  - Medicare publications
  - Local and National Coverage Determinations (LCDs/NCDs)
  - Outpatient Code Editor (OCE)
  - Medicare Code Editor (MCE)
  - Center for Medicare and Medicaid (CMS)
  - Ohio Department of Medicaid (ODM)

What do you need to do?

- Many other carriers whom you work with already use Optum's CES. Therefore, we do not anticipate that this implementation will cause any disruptions or delays to your work with PARAMOUNT. CES will replace our legacy edits, and automatically review and catch errors, omissions and questionable coding. The end result will be streamlined claims, reduced reimbursement errors and improved payment integrity. All edits are transparent, and you will be able to look up specific claims to see any edits as well as sourced citations.

Reimbursement Policy Updates
Effective June 1, 2020

New Reimbursement Policy | Maximum Frequency per Day/MUE: RM-008

- **Effective for all product lines**
- Paramount will reimburse physicians and other qualified healthcare professionals for units billed, without reimbursing for obvious billing submission and data entry errors or incorrect coding, based on the following:
  - Anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established Paramount policies, and nature of a service/procedure, equipment, and unlikely clinical treatment.

PARAMOUNT
Affiliate of ProMedica

New Reimbursement Policy | Multiple Procedure Payment Reduction for Medical and Surgical Services, Professional: RM-011

- **Effective for all product lines**
- Paramount will apply Multiple Procedure Reductions in accordance with CMS methodologies in determining which procedures are subject to multiple procedure reductions.

New Reimbursement Policy | Anesthesia Rounding: RM-012

- **Effective for all product lines**
- Paramount will now be following CMS guidelines for time unit rounding. Time spent performing anesthesia services will now be reported in one-minute increments and noted in the unit's field.
    - Please do not estimate the time or round up or down inappropriately. To calculate reimbursement for time, the number of minutes reported is divided by 15 (minutes) and rounded up to the next tenth to provide a unit of measure. Example: 61 minutes divided by 15 = 4.0666 units. Reimbursement for time will be rounded to 4.1 units instead of using a whole 5 unit of measure.

Medical Policy and Prior Authorization Updates Effective April 1, 2020; May 1, 2020; and Immediately

---

Updated Medical Policy | Interventional Pain Management Injections: Sacroiliac, Epidural Steroid, Facet, and Trigger Point: PG0354

- **Effective for all product lines, immediately**
- Facet Joint Injections r/t coverage criteria additions and Sacroiliac Injections r/t CPT codes 27096, 64451 and G0260.
- Diagnostic facet joint injections are considered experimental and investigational for neck and back pain with untreated radiculopathy. CPT codes 27096, 64451 and G0260 should not be billed when a physician provides routine sacroiliac injections. CPT codes 27096, 64451 and G0260 are to be used only with imaging confirmation of intra-articular needle positioning. Paravertebral Spinal Nerves and Branches – image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 27096. Do not report CPT code 27096 or G0260 unless fluoroscopic or CT-guidance is performed.

New Medical Policy | Genetic Testing for Epilepsy: PG0467

- **Effective for all product lines, May 1, 2020**
- Genetic testing for epilepsy requires prior authorization. If multi-gene panel testing is being pursued, more targeted panels are preferred. If clinical findings dictate that a more targeted panel is appropriate, a broader multi-gene panel may not be considered medically necessary.

New Medical Policy | Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS): PG0468

- **Effective May 1, 2020**
  - **HMO, PPO, Individual Marketplace, and Advantage Medicaid:** Whole Exome Sequencing (WES) requires a prior authorization.
  - **Elite Medicare:** Whole Exome Sequencing is non-covered.
  - **HMO, PPO, Individual Marketplace, and Elite Medicare:** Whole Genome Sequencing (WGS) is non-covered.
  - **Advantage Medicaid:** Whole Genome Sequencing (WGS) requires prior authorization.

Updated Medical Policy | Acupuncture, PG0382

- **Effective for Elite Medicare, May 1, 2020**
- A prior authorization is now required for the Elite product line after the first 12 visits, for the additional 8 visits.

New Medical Policy | Non-Medical IV Hydration Therapy Services: PG0470

- **Effective for all product lines, April 1, 2020**
- Non-medical IV hydration therapy services outside of Standard Medical Practices are non-covered.

For more information, please reference each complete policy on our website. Visit our online medical and reimbursement policy libraries:

- paramounthealthcare.com/medicalpolicies
- paramounthealthcare.com/reimbursementpolicies

IMPORTANT: All referenced policies will be available to view on our website 30 days prior to their effective date. We cannot guarantee that they will be uploaded prior to this date.

If you have questions regarding this notice, or other issues, please contact your Provider Relations Representative or call Provider Relations at 800-891-2542.