BlueCross BlueShield of Montana

BLUE REVIEW℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS — SECOND QUARTER 2017

INSIDE THIS ISSUE

Real Time Notification of Preauthorization's and Predeterminations

Beginning July 1, 2017, we implemented electronic facsimile (fax) notification of benefit preauthorization and predeterminations to the requesting provider. This enhancement provides real time information and eliminates the need for providers to check the status of preauthorization or predetermination requests while waiting on the mailed notification letters. The faxed notification will be in addition to the notification letter delivered via mail, to the mailing address we have on file for you.

Notifications will be faxed to the number on file for you, or the number listed on the utilization management or clinical request or clinical we received from you. You can also check the status of your submitted request via iExchange.

As a reminder, because we are sending confidential protected health information (PHI) to your fax machine, it should be in a secure location that is not accessible to those who do not have the authority to review member/patient PHI.

If you do not wish to receive faxed notifications, please contact your Blue Cross and Blue Shield of Montana (BCBSMT) Provider Network Representative.

Please note that information regarding eligibility and benefits and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

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Our *Blue Review* provider newsletter is produced quarterly for participating professional and institutional providers across all lines of business (commercial and government programs). The newsletter serves as a vehicle to communicate timely, consistent and relevant messaging related to:

- New products, programs and services available at BCBSMT
- Notification of changes as required by contract or other mandates
- Member initiatives and patient resources

Air Ambulance Services

BCBSMT continues to work with our network hospitals and providers in the state to mitigate the impact of the health care costs that continue to reach unprecedented levels for Montanans. Among those contributing factors is the use of out-of-network providers, which can create avoidable financial hardships for your patients, our members. To address that issue, BCBSMT is currently focusing on the immediate concerns with out-of-network air ambulance services. Included below is a directory of current BCBSMT participating air ambulance providers to assist our members and your patients in seeking quality, affordable care.

To ensure our members receive the full air ambulance benefits of their BCBSMT health care plan, we urge you to transport our members via in-network air ambulance providers whenever possible, to avoid balance billing and potentially save your patients thousands of dollars.

Thank you for all you do to ensure the health and well-being of our members, and we appreciate your efforts to ensure that your patients continue to receive the best care possible without the adverse impacts of out-of-network costs.

Should you have any questions about this communication, please contact us at **1-800-447-7828**, Extension 6100 or at HCS-X6100@bcbsmt.com.

Air Ambulance Providers for Blue Cross and Blue Shield of Montana (BCBSMT)			
Provider	**Phone Number**	**Rotor**	**Fixed Wing**
Benefis Healthcare	Mercy Flight Communication Center at 1-800-972-4000	•	•
Billings Clinic Hospital	1-800-325-1774		•
Kalispell Regional Hospital	1-866-302-9767	•	•
MT Medical Transport	406-457-8205		•
Northeast Stat Air	Dispatch Line: 1-800-992-7828 (Montana toll-free); 406-228-3500 (Out of State)		•
St Vincent's Healthcare	1-800-JET-HELP (1-800-538-4357)	•	•

Disclaimer: A provider's participation status may change. Contact Customer Service using the phone number on the back of the members health plan ID card to obtain the most up to date information.

The providers listed above are independently contracted companies that provide air ambulance transportation services for Blue Cross and Blue Shield of Montana. These air ambulance providers are solely responsible for the products and services that they provide.

Healthy Montana Kids (HMK)

HMK has implemented a dedicated phone and fax line for preauthorization requests. Please use the following information:

- For pre-authorization, **855-699-9907**
- HMK Intake Fax line, **855-610-5684**

Provider Manuals

BCBSMT reviews and updates the following Provider Manuals;

- HELP Plan Provider Manual
- Medicare Advantage (MA) Provider Manual
- Commercial Provider Manual

Currently, BCBSMT is finalizing the updates to the HELP Plan Provider Manual and the MA Provider Manual. The updated versions will be posted to the Provider Portal by the end of the 2nd quarter.

Medicare Advantage Preauthorization Requirements through eviCore

Effective June 1, 2017, BCBSMT has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide preauthorization review services for the following benefit plan(s):

- Blue Cross Medicare Advantage (PPO)SM
- Blue Cross Medicare Advantage (HMO)SM

eviCore will manage preauthorization for the following specialized clinical services:

- Outpatient Molecular Genetics
- Outpatient Radiation Therapy
- Musculoskeletal
  - Chiropractic
  - Physical and Occupational Therapy
  - Speech Therapy
  - Spine Surgery (Outpatient/Inpatient)
  - Spine Lumbar Fusion (Outpatient/Inpatient)
  - Interventional Pain
- Outpatient Cardiology & Radiology
  - Abdomen Imaging
  - Cardiac Imaging
  - Chest Imaging
  - Head Imaging
  - Musculoskeletal
  - Neck Imaging
  - Oncology Imaging
  - Pelvis Imaging
  - Peripheral Nerve Disorders (Pnd) Imaging
  - Peripheral Vascular Disease (Pvd) Imaging
  - Spine Imaging
- Outpatient Medical Oncology
- Outpatient Sleep
- Outpatient Specialty Drug

Services performed without preauthorization or that do not meet medical necessity criteria may be denied for payment, and the rendering provider may not seek reimbursement from the member.

You will continue to use iExchange for all other services that require preauthorization.

BCBSMT and eviCore will provide additional information, including training opportunities, in the coming months on the Provider website at bcbsmt.com/provider and in *Blue Review*. You may also contact your Provider Network Representative for more information.

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSMT.

Preauthorization determines whether the proposed service or treatment meets the definition of medical necessity under the applicable plan. Preauthorziation of a service is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

Medicare Advantage Overpayment Recovery

A new process was implemented for overpayment recovery on claims processed after January 1, 2017.

- The Electronic Refund Management and Claim Inquiry Resolution tools on Availity are no longer available for government programs claims.
- Request for refund letters are sent by mail when overpayments are identified on government programs claims.
- Please review your refund letter closely and remit your refund to the address indicated on the letter. Please include a copy of your refund request letter along with your refund.
- If you identify an overpayment and wish to send a voluntary refund, please use the following grid to determine the appropriate address:

Product	Original Claim Date	Send to Address
MA	**Pre 1/1/17**	P.O. Box 5089 Helena, MT 59604-9954
MA	**Post 1/1/17**	Health Care Service Claims Overpayment 29068 Network Place Chicago, IL 60673-1290

- In the event that you are unsure about the original payment date, please send payments to:

  Health Care Service Corporation
  P.O. Box 731431
  Dallas, TX 75373-1431

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSMT. BCBSMT makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Has your information changed? Let us know!

When seeking health care services, our members often rely upon the information in our online Provider Finder®. In particular, potential patients may use this online tool to confirm if you or your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder when referring their patients to your practice.

We encourage you to check your own information in the Provider Finder – look for the link on our Provider website Home page at bcbsmt.com/provider. Is your online information accurate? If changes are needed, it's important that you inform BCBSMT as soon as possible.

USE OUR ONLINE CHANGE REQUEST FORMS

For ease of use, we have placed the Update Office Information form in three different locations to help you update your information:

- Visit the **Network Participation/Update Your Provider Network/Information** (printed and faxed/mailed)
- Visit the **Education and Reference/Forms and Documents** (printed and faxed/mailed)
- Log into the Secured Provider Portal, and access the **Update Office Information** link (automatic submission).

You can request most changes online by using one of our electronic change request forms and the instructions are included on each form.

You can request various different changes using the forms which guide you in organizing your information, as follows:

1. **Request Demographic Information Changes**
   Use this form to request changes to your practice information currently on file with BCBSMT (such as address, email or NPI). You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI. As a participating provider, your NPI(s) should already be on file with BCBSMT. You may use this online form to request changes, such as deactivation of an existing NPI.

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Medical Policy Updates

Medical policies, both new and revised, are used as guidelines for benefit determinations in health care benefit programs for most BCBSMT members, unless otherwise indicated. These policies may impact your reimbursement and your patients' benefits. You may view active, new and revised policies, along with policies pending implementation, by visiting the **Standards and Requirements/Medical Policy** section of our Provider website. Select "View all Active and Pending Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the **Medical Policies** Home page.

You may also view draft medical policies that are under development, or are in the process of being revised, by selecting "View and comment on Draft Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the **Draft Medical Policies** page. Just click on the title of the draft policy you wish to review, and then select "Comments" to submit your feedback to us.

Please visit the **Standards and Requirements/Medical Policy** section of our Provider website for access to the most complete and up-to-date medical policy information.

The BCBSMT Medical Policies are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSMT, such as some self-funded employer plans or governmental plans, may not utilize BCBSMT Medical Policies. Members should contact the customer service number on their member ID card for more specific coverage information.

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2. **Request an Additional Location**
   Use this form to notify BCBSMT that a new location needs to be added to your Provider practice. Please remember to include an effective date and the appropriate payment address information.

3. **Request Removal of Provider from Group**
   Use this form to notify BCBSMT when an individual provider is leaving any or all of your practice locations.

Please note that changes are not immediate upon submission of an online change request form. Processing can take a minimum of 30 business days. If you would prefer to mail or fax your changes to BCBSMT, there is a downloadable **Provider Information Change Request Form** in the **Education and Reference/Forms** section of our Provider website. If you have any questions or need assistance, contact Network Management at HCS-X6100@bcbsmt.com.

EXCEPTIONS TO THE ONLINE REQUEST PROCESS

The following types of changes are more complex and require special handling:

- **Multiple changes, especially changes involving more than one billing NPI –** This type of change or request should be submitted via email to HCS-X6100@bcbsmt.com, or by calling **800-447-7828** extension **6100**.
- **Tax ID changes that involve Legal Business Name changes –** This type of change often requires a new contract. To request a contract application, visit the **Network Participation/Contracting** section of our Provider website.
- **Ancillary provider changes –** Skilled nursing facilities, home health agencies, hospice, home infusion therapy, durable medical equipment (DME) suppliers, orthotics and prosthetics, dialysis centers, and other ancillary providers may request changes by sending details to HCS-X6100@bcbsmt.com, or by calling **800-447-7828** extension **6100**.

ClaimsXten Quarterly Updates

New and revised Current Procedural Terminology® (CPT) and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version. BCBSMT will normally load this additional data to the BCBSMT claim processing system within 60 to 90 days after receipt from the software vendor and will confirm the effective date via the **News and Updates** section of the BCBSMT Provider website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on the BCBSMT Provider website.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSMT's code-auditing software. Refer to our website at bcbsmt.com/provider for additional information on gaining access to C3.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the **Clear Claim Connection™** page. Additional information also may be included in upcoming issues of *Blue Review*.

FEP Self-Measured Blood Pressure Monitoring

The Blue Cross and Blue Shield Federal Employee Program® (FEP) and the American Medical Association (AMA) are working together to provide physicians with resources designed to help improve health outcomes for patients with hypertension or suspected hypertension. This effort supports the goals of the Million Hearts® initiative.

Information covering self-measured blood pressure monitoring, a component of the Improving Health Outcomes: Blood Pressure Program developed by the AMA, is designed to help you and your office staff engage your patients in the self-measurement of their own blood pressure.[1] According to a 15-member task force appointed by the Centers for Disease Control and Prevention (CDC), when physicians and their office staff engage their patients in the self-measurement of their own blood pressure combined with additional support (i.e., patient counseling, education or web-based support), self-measured blood pressure monitoring becomes very effective and cost efficient.[2]

In support of this effort, FEP initiated a program to provide free blood pressure monitors* to FEP enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If your patient completes the Blue Health Assessment (BHA) and reports they have high blood pressure and you and your patient discuss home monitoring, your patient is eligible to receive a free blood pressure monitor. The BHA is a health-risk assessment and the first step in the FEP Wellness Incentive Program. In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle. FEP members can go to fepblue.org for more information.

Please do not hesitate to contact FEP Customer Service at **800-634-3569** for more details regarding this program.

[1] American Medical Association Practice Improvement Strategies, Steps Forward Program, https://www.stepsforward.org/

[2] Cardiovascular Disease: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Used Alone, June 2015, http://www.thecommunityguide.org/cvd/RRSMBP.html

*The blood pressure monitors were selected by BCBS. The AMA does not endorse any particular brand or model of blood pressure monitor.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

BlueCard Program Manual Reminders

To assist you when you are providing care and services to out-of-area Blue Plan members, a **BlueCard Program Manual** is available in the Standards and Requirements section of our website at bcbsmt.com/provider.

This manual includes information on how the BlueCard program works, how to identify BlueCard members, claim filing guidelines, key contacts, answers to frequently asked questions, a glossary of BlueCard terms and other important details.

Examples of specific sections included in the **BlueCard Program Manual** are:

- BlueCard Program Advantages for Providers
- Coverage and Eligibility Verification
- Electronic Provider Access
- Ancillary Claims
- Contiguous Counties/Overlapping Service Areas

We encourage you to become familiar with the procedures and guidelines in this helpful resource.

Professional and Outpatient Facility Payment Policies for Members enrolled in Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage (PPO)

Effective March 15, 2017, BCBSMT enhanced our review and application of our physician payment policies applicable to Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage (PPO) .

There are no changes required by providers. The payment policies for the Blue Cross Medicare Advantage plans will continue to be based on nationally accepted means of claims payment, which include:

- Medicare's:
  - National bundling edits including the Correct Coding Initiative (CCI)
  - Modifier usage
  - Global surgery rules
- AMA CPT coding guidelines
- Regional Medicare policies
- National specialty academy guidelines (coding and clinical).

As a valued provider please continue to render services to our members and submit your claims, accordingly. The goals of this endeavor are to:

- Enable you and your billing staff to more readily understand our payment of claims given the widespread use of these policies and source criteria utilized above.
- Identify that the service or drug being requested is medically necessary and appropriate by following up-to-date medical recommendation treatment plans that are not duplicated.

Effective May 9, 2017, BCBSMT enhanced our review and application of our Outpatient Facility Claims payment policies applicable to Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage (PPO) .

There are no changes required by providers. The payment policies for the Blue Cross Medicare Advantage plans will continue to be based on nationally accepted means of claims payment, which include:

- Medicare's:
  - National bundling edits including the Correct Coding Initiative (CCI)
  - Modifier usage
- CMS Coverage Policies
- Duplicate Services Policy
- Bundled Services Policy
- Diagnosis Code Guideline Policy
- Maximum Units Policy
- Revenue Code Policy
- CMS National Coverage Determinations (NCD) Policy
- Multiple Procedure Reduction for Therapy Services Policy
- National Correct Coding Initiative Policy
- AMA CPT coding guidelines
- Regional Medicare policies
- National specialty academy guidelines (coding and clinical).

This is one of many things we are doing to make the health care system work better, by focusing on improving health care delivery. We want our members to receive the best health outcomes for all the dollars spent on their care.

We will be providing additional information on the BCBSMT Provider website and in later *Blue Review* issues.

Spring Provider Workshops

BCBSMT's Network Management Team held Spring Provider Workshops the second week of May and educated approximately 482 individuals ranging from billing staff, registration staff, front office staff, to providers of varying specialties. The Network Management Team educated providers on the following topics:

- BlueCard Program
- May 1, 2017 Fee schedule updates
- Medicare Advantage Changes and Prior Authorization
- The HELP Plan
- BCBSMT website and provider portal overview
- Blue Focus POS℠ / Blue Options℠
- Air Ambulance
- Availity

The Provider Workshops were held in the following locations;

- May 8, 2017 | Bozeman, MT
- May 9, 2017 | Billings, MT
- May 9, 2017 | Great Falls, MT
- May 10, 2017 | Helena, MT

New ClaimsXten Rules to be Implemented

Beginning on or after September 18, 2017, BCBSMT will implement 4 new rules to the ClaimsXten software database. These new rules are defined as:

- **Add On Without Base Code** – This rule will identify claim lines containing a CPT/HCPCS add-on- code billed without the presence of one or more related primary service/base procedure codes. According to American Medical Association (AMA), *"add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code."*
- **Global Component Billing** – This rule will identify procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule will also identify when duplicate submissions occur for the total global procedure or its components across different providers
- **Duplicate Component Billing** – This rule identifies when a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same member for the same date of service.
- **New Patient Code for Established Patient** – Identifies claim lines containing new patient procedure codes that are submitted for established patients. According to AMA, *"A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last 3 years."*As well, similar guidance is provided by Centers for Medicare Medicaid Services (CMS): According to Pub 100-04, Medicare Claims Processing Manual Ch. 12, Physicians/Non-Physicians Practitioners, Section 30.6.7, Subsection A, "*Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years."*

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Education & Reference/Provider Tools/Clear Claim Connection page on our Provider website at bcbsmt.com/provider. Information also may be published in upcoming issues of the *Blue Review*.

Checks of eligibility and/or benefit information are not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Provider Learning Opportunities

A snapshot of complimentary upcoming training sessions offered by BCBSMT is included below. To register, visit the Training page in the Education and Reference Center on our website at bcbsmt.com/provider.

BCBSMT WEBINARS

BCBSMT: Availity™ Provider Training
Monday, June 19, 2017
Wednesday, June 21, 2017
Monday, June 26, 2017
Wednesday, June 28, 2017

Remittance Viewer
Tuesday, June 20, 2017

iExchange Training: 2017 System Enhancement
Tuesday, June 13, 2017

Colorectal Cancer Screening Capacity in Montana

There are about 500 new cases of colorectal cancer (CRC) in Montana each year and CRC is the 2nd most common cause of cancer deaths with 180 deaths each year.[1,2] CRC screening can significantly reduce deaths by diagnosing cancers early and even prevent new cases from developing, yet 2 in 5 Montanans aged 50 to 75 years are not up-to-date with CRC screening.[3,4] Increasing CRC screening rates is a public health priority that requires insurers, healthcare providers, and public health organizations to work together.

80% BY 2018 IN MONTANA

The American Cancer Society and the Centers for Disease Control and Prevention are leading a national effort to ensure that 80% of adults aged 50 to 75 are receiving recommended CRC screening by 2018. Hundreds of organizations across the nation have pledged to pursue this goal in their own community. In Montana, the Department of Public Health and Human Services along with 12 other organizations have also pledged to do this.

For average risk, asymptomatic adults aged 50 to 75 years, the United States Preventive Services Task Force (USPSTF) recommends one of three CRC screening tests:

- Annual screening with high-sensitivity fecal occult blood testing (FOBT)
- Sigmoidoscopy every 5 years with high-sensitivity FOBT every three years
- Screening colonoscopy every ten years.[3]

Sixty-two percent of Montana's 326,000 adults aged 50 to 75 years reported having met USPSTF recommendations for CRC screening in 2014 (Figure 1).[4] Achieving our goal of 80% by 2018 would require about 59,000 more Montanans to get screened.

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80% BY 2018
COLORECTAL CANCER SCREENINGS

Montana Organizations That Have Taken The 80% by 2018 Pledge

- Blue Cross Blue Shield of Montana
- Central Montana Family Planning
- Central Montana Health District
- Central Montana Medical Center
- Community Health Care Center
- Community Medical Center
- Kalispell Regional Healthcare
- Lewis and Clark Public Health
- Montana Cancer Coalition
- Montana Department of Public Health and Human Services
- Montana Primary Care Association
- RiverStone Health
- Rocky Mountain Tribal Leaders Council

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COLONOSCOPY CAPACITY ACROSS THE STATE

Among Montanans who report meeting CRC screening recommendations, 60% were screened via colonoscopy and only 7% were screened via annual FOBT.4 Since colonoscopy is a major CRC screening modality and positive FOBT tests require a diagnostic colonoscopy, meeting our goal of 80% by 2018 is highly dependent on adequate capacity to perform colonoscopies across the state.

To assess the current colonoscopy capacity in Montana, DPHHS surveyed health care facilities that performed colonoscopies in the summer of 2016. Forty-three of the 44 facilities surveyed responded to the questionnaire. Thirty-five reported currently performing colonoscopies. All responding facilities reported:

- the average number of colonoscopies completed each month over the past 12 months
- the maximum number of colonoscopies they could complete each month without any added investment of resources, and
- the approximate wait time for a colonoscopy at their facility.

Collectively, Montana facilities reported completing almost 3,000 colonoscopies each month (Figure 2). However, only two thirds of the total colonoscopy capacity in the state is currently being used. If all facilities were operating at their full reported capacity, there would be an additional 1,800 colonoscopies performed each month. This increase in colonoscopies would be enough to screen an additional 21,600 people each year. That is more than a third of the Montanans that need to be screened to reach our goal of 80%.

MONTANA CANCER CONTROL PROGRAMS CAN SUPPORT PHYSICIANS AND CLINICS TO IMPROVE CRC

The Montana Cancer Control Programs (MCCP) work with statewide partners, such as medical providers, to implement evidence based policy and system changes. The MCCP is currently working with federally qualified health centers to implement provider assessment and feedback tools and implement client and provider reminder systems.

In partnership with two Montana health systems, MCCP has conducted provider trainings on colorectal cancer screening guidelines and evidence based interventions. These trainings have addressed CRC office practices and data quality, and office policy and flow for CRC screening and follow-up. The MCCP is particularly interested in conducting similar work with other health systems in Montana over a multi-year period. Interested organizations can contact Leah Merchant at the number below.

The MCCP offers technical assistance to providers and clinics to assess EHR systems and ensure accuracy of colorectal cancer screening data for patient records, screening, follow-up and diagnosis. MCCP welcomes provider input and inquiries on the topics of provider education, health system change, and EHR assistance for colorectal screening. Contact **Leah Merchant**, **406-444-4599** or lmerchant@mt.gov, for more information.

References

1. Montana Department of Public Health and Human Services, Montana Central Tumor Registry, 2006–2015.
2. Montana Department of Public Health and Human Services, Montana Office of Vital Statistics, 2006–2015.
3. U.S. Preventive Services Task Force. Final Recommendation Statement: Colorectal Cancer Screening. Accessed on March 6, 2017 at https://www.uspreventiveservicestaskforce.org/BrowseRec/Index
4. Montana Department of Public Health and Human Services, Montana Behavioral Risk Factor Surveillance System, 2014.

FIGURE 1

Of the 326,000 Montanans aged 50 to 75, 62% (about 202,000) were up-to-date on CRC screening in 2014.

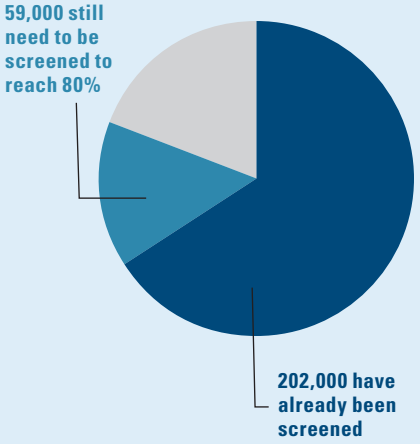


FIGURE 2

Montana healthcare facilities reported using about 2/3 of their total colonoscopy capacity each month.

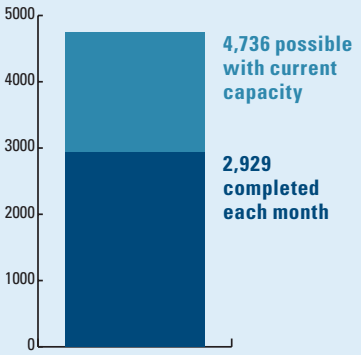
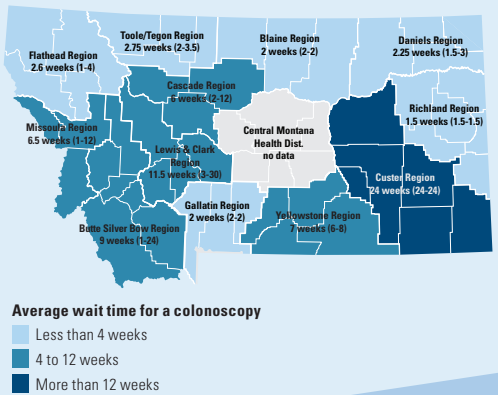


FIGURE 3

Average wait time to schedule a colonoscopy by region



CNI Advantage, LLC to Begin PERM Medical Review Process

CNI Advantage, LLC will begin the Payment Error Rate Measurement (PERM) medical record review process in May, 2017. PERM participation is required under the Federal Improper Payments Elimination and Recovery Act (IPERA) of 2010. CNI will begin contacting providers for CHIP and Medicaid claims that have been sampled for review. Providers are encouraged to respond to CNI within the given timeframe, submit all requested documentation, and return the documentation with the claim-specific cover letter for each claim pulled for review.

Please contact **Krista Cronholm** with DPHHS Program Compliance Bureau for any PERM questions at **406-444-9365**, KCronholm@mt.gov.

Providers may also visit the CMS provider web page at any time to become familiar with the entire PERM Process.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Providers.html

Blue Review is a quarterly newsletter published for institutional and professional providers contracting with Blue Cross and Blue Shield of Montana. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at bcbsmt.com/provider.

The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

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