Blue Cross Blue Shield Blue Care Network of Michigan

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EMR/DMR Frequently Asked Questions

How to Submit Data:

1. **How do I submit issues/questions about the EMR/DMR electronic data exchange process?**
   You may submit issues or questions through the PGIP Collaboration site issues log. Please select "Supplemental Information" as the issue category.

2. **Why do I have to submit data for my practices when they have access to Health e-Blue Web?**
   POs are not required to submit HEDIS supplmental data, however, submitting data may help to improve your PO's performance.
   Currently, you can only enter data on Health e-Blue for BCN and BCBSM Medicare Advantage PPO members. There are plans to expand this functionality to BCBSM Commercial members, but it is not available at this time.

   Until your PO has passed all milestones of theEMR/DRM data exchange process, you should continue to have your practices submit data through Health e-Blue Web for BCN and BCBSM Medicare Advantage PPO members.

   Once your PO is submitting production files through EMR/DMR electronic data exchange, you can submit data for BCN, BCBSM Commercial and BCBSM Medicare Advantage PPO members via the batch EMR/DMR electronic data exchange process, via the practice through Health e-Blue Web, or both.

3. **How often does my PO need to submit supplemental information?**
   BCBSM requires monthly file submissions. After you submit your firest production file, we will accept a historical data file, and then expect incremental files. Once you submit data for an existing member for a specific measure, you will not have to submit the same data again. For new members, please send us a complete historical load.

4. **Only one of our provider NPIs is listed in the [CMI NPI List] within the BCN+ Data+Exchange+Layout+V20+Groups+Phase2.xlsx workbook. Is this only a sample of the complete list? Where would I find a complete list of providers?**
   Yes the document lists a very small subset of the complete CMS NPI list. The top of the "CMS NPI List" worksheet provides the link to the CMS website to download the complete list.

5. **Will it be an issue to send duplicate data from upload to upload?**
   *Yes. Once you are in production, the Blues should receive **incremental data only** on a monthly basis. For your first file submission we will request a onetimehistorical fileto be sure we capture appropriate data for measures that have a longer look back period. We would suggest that you use the YRS_History column in the HEDIS CODE REF tab of the file layout document which lists the years of history by code.*

Differences between BCN and BCBSM:

6. **We are currently submitting data for both BCN and BCBSM members. What if I want to change our current process?**
   If you'd like to change how you currently submit data, for example, sending us split files instead of one consolidated file, please contact your field representative. Typically, BCN and BCBSM require a two week notice for such a change.

The File Layout and Required Fields:

7. **Where can I find updated file layouts and mapping tables? How will I keep track of en they are updated?**
   You can located all versions of the file layout on the PGIP Collaboration Site. When the versions are updated an announcement is made on the site, you will be notifiedvia ur email if you have set alerts for annoucements on the EMR/DMR data exchnge initiative page. If you submit data through a vendor, you are responible for alerting the vendor of changes to the file layout.

8. **Will the combined BCN/BCBSM data file layout be similar to the BCN layout?**
   Yes, it is the same file layout.

9. **Are there any required data fields when I submit information?**
   Yes. The file layout provides information on required data fields in the "data dictionary" tab.

10. **Will BCBSM require negative eye exams in the future?**
    Yes, we will be requiring negative eye exams in the future. The HEDIS measure looks for an eye screening for diabetic retinal disease, identified through a retinal or dilated eye exam by an eye care professional or a negative retinal or dilated eye exam by an eye care professional.
    a. *To be clear...HEDIS allows us to count an eye exam in the previous year only if it was negative for retinopathy. We would like to receive the result on diabetic eye exams for retinopathy whether positive or negative – not just negative exams. Monitoring for nephropathy in diabetics can be determined by sending us a microalbumin (any provider), positive macroalbumin (any provider) OR a*

nephrologist visit. If you want to tell us about a nephropathy visit we would need the servicing provider.

11. **In the file layout we see a service type code for tobacco counseling (TB), but no code for smoking status. Are we missing something?**
Smoking status is not collected

12. **The PO's past submissions have included a separate record for each qualifying diagnosis, CPT or lab value in our data, even if they represent the same event. This creates significant duplication. If we combine these records into one and submit records with CPT, diagnosis codes and potentially lab values will this create any problems and which record type should we use?**
Current EMR/DMR Data Exchange processes cannot handle a combined record as suggested above at this time. Each item will need to be sent separately. The Blues will make note of the request for process improvements.

13. **There are several fields in BCBSM membership files that represent member name (SubscriberName, MemberName which is often blank, MemberNameAlt) which ones are used when identifying BCBSM members in the file?**
Please use the following algorithm for names:
First, use "MemberLastNameAlt|MemberFirstNameAlt", if not available then use "MemberLastName|MemberFirstName|", if neither of the aforementioned fields are available, then use "SubscriberLastName|SubscriberFirstName|".

14. **Which field should we use between the following options, and how can you tell the difference between members of a family on the same contract?**
-Contract Number
-Contract Number Alt
-Member ID?
Do not use the "Pre_MemberID". Instead use the "ContractNumberAlt" as this is a de-identified number. If not available, then use "ContractNumber." Although "ContractNumber" is not unique to the member, a part of our matching algorithm has to do with member first name, date of birth and gender. So if an entire family has the same contract number, the next step is to look at the first name, then birth date, then gender. This is why if "ContractNumberAlt" is not availablewe suggest using "ContractNumber."

15. **Regarding "Measure"-"Other," there is not a Code_Value associated with them. How will BCBSM capture this data without one and would should this be reported?**
You will want to use the "SRV_CD" which is found in column G. Another tip is that you can use "SRV_CD" instead of a CPT code on any measure. This becomes helpful when a) there is not a CPT code available (similarly to the original question) and b) for Diabetic Eye Exam, Glaucoma Screenings, and Nephrology Exams which must inclue the servicing

provider if you send a CPT code, you can submit the "SRV_CD" instead of the CPT code and not have to submit a service provider.

16. **Our PO has physicians who have been recording declined flu services. Is it acceptable to include declined services?**
    It is not acceptable to send declined services because in ourproduction environment there is no way to differentiate that the service was declined.

Pre-Audit Process:

17. **Why does my data need a pre-audit?**
    In order for the Blues to accept provider data from an Electronic Medical Record (EMR) or Disease Management Registry (DMR) we must perform a medical record audit based on electronic test data that was submitted. The purpose of the audit is to determine whether the data returned to us on your behalf can be reasonably supported by documentation in your patient medical records. In order for Physician Organizations (POs) to move from a testing phase to production the pre-audit must be completed. All Physician Organizations must complete a pre-audit.

18. **What does the pre-audit entail?**
    The pre-audit entails BCBSM/BCN pulling a sample of the test records submitted by your PO, which includes all service types you plan to send. The sample is then sent to the PO, who works with physician offices to secure medical record documentation and returns it to BCBSM/BCN. The Blues will confirm that everything flows through the electronic exchange process as required and the data match the patient health record.

19. **How will I get my sample?**
    Your sample will be posted to your EDDI box. After your test file passes IT testing, your file will go through a pre-audit check, where we make sure that all the population information we are looking for in an audit will be present. The Blues will contact your PO via email once we have completed your pre-audit check and the email will include instructions along with a list of the patient(s) and their services along with a "Fax Cover Sheet for EMR/Electronic Data Exchange Audit."

20. **What do I do next?**
    Review your patient list and services and provide secure copies of the pages in the patient's medical record where this information was obtained. Return those pages using the "Fax Cover Sheet for EMR/Electronic Data Exchange Audit" to fax 1-866-915-9432.

Helpful Tips for HEDIS Improvement (Closing Gaps and Services):

21. Can a PO submit information that would exclude an attributed patient from the denominator on the PGIP EBCT report?
POs have the ability to submit exclusion information which would permanently exclude a member from a specific HEDIS ® measure. For example, a patient who has a history of a hysterectomy would be an exclusion from the Cervical Cancer Screening measure.

Currently, the EMR/DMR process cannot remove a patient from your PO's PGIP-attributed membership. For example, a PO may identify attributed patients that the primary care physician (PCP) has deemed "not my patient."

POs can submit information about recently deceased patients. This information will be factored into future PGIP-attributions and removed from appropriate demoninators.

22. Why does BCBSM require a servicing provider for a well-child visit when it should be provided on the claim? The file layout states, as well as our error report that "If you want to get credit for glaucoma screenings, retinal eye exams, visits with a Nephrologist, or well child visits, you must populate either the SERVICE_PROVIDER_MI_LIC_NUM or the SERVICE_PROVIDER_NPI." How should we provide this?
The electronic data exchange is meant to supplement what BCN/BCBSM may have received on a claim. We need to know that the service was performed by a primary care physician or in the case of adolescent well care a PCP or Ob/Gyn.

23. In regards to the Diabetic Retinal Exam, do the offices need to have something scanned into the EMR to provide proof of the eye exam or is a verbal message from the patient sufficient?
Verbal confirmation from the patient is not enough. A copy from the opthomologist or optometrist report would need to be in the EMR.

24. If an attributed patient has a condition which excludes him/her from a measure (double mastectomy for breast cancer screening) will that information need to be re-submitted to BCN/BCBSM annually?
No.

25. In regards to the FIELD DESCRIPTIONS of DIAG_I_N for Gaps in Care records, while the [Record Level Validation Rules] worksheet indicates that for all RECORD_TYPEs of 'D', the submission type must be Additional Diagnosis. Is it being requested that I provided the HEDIS CODE RED subset of diagnoses for service records where one or more of these dx codes were identified?
The source for DIAG_I_N fields vary depending on the SUBMISSION_TYPE. If the

SUBMISSION _TYPE='A' the source for DIAG_I_N fields would be the CCC Diagnosis Codes, but if the SUBMISSION_TYPE='G', the source for DIAG_I_N fields would be the HEDIS CODE REF subset of Diagnosis codes. Refer to Error Code 20 on "Record Level Validation Rules" worksheet.

26. **How would we send a visit to a nephrologist that counts for 'Evidence of diagnosis or treatment for nephropathy' for Diabetes? The HEDIS specs do not require any specific diagnosis or procedure code, just a visit to a specialist identified as a nephrologist via specialty provider codes—would we just use record type of 'S', service type code 'MC' and not populate the CPT_HCPCS, REVENUE_CODE or diagnosis fields?**
Yes . Use the record type of 'S', service type code 'MC' and not populate the CPT_HCPCS, REVENUE_CODE or diagnosis fields.

Additional Questions:

27. **Retinal eye exams, colorectal cancer and prenatal/postpartum care are all measures that are weighted more heavily. Why is this the case?**
These measures are more heavily weighted for payments to align with NCQA and MA Stars Accredidation weights.

28. **In the past, despite sending G & V codes to help close gaps in care, the gaps did not show as "closed." How has this issue been solved?**
Previously BCBSM only pulled the "primary" diagnosis code on the claim, which would not allow us to see the G & V codes. However, we now pull all 15 columns and this information will now be updated on the PO Dashboard starting in 2014.

29. **Can the Blues accept BMI measures?**
The Blues NCQA audit firm has ruled that BMIs that are calculated by a Disease Management Registry (DMR) will not close a treatment opportunity for Adult BMI.

To satisfy a treatment opportunity for adult BMIs, you may include the appropriate V-code along with professional service billed on the claim.

Data may also be provided via an EMR record included on the EMR/DMR Data Exchange file layout. If your PO uses this option for providing standard supplemental data, the patient's legal medical record (EMR or paper) must include the BMI value or a BMI percentile for a child. Patient height and weight must also be reported on a separate row.

POs using a DMR to send data via the EMR/DMR Data Exchange may only send BMI records that are sourced from an EMR using the above guidelines. The Blues has released an updated file layout (Version 23) that include two additional data source fields.

This ruling will not impact PGIP incentive payments for the 2013 HEDIS year. This ruling will not impact BCN incentive payments for the 2013 HEDIS year. This ruling will impact BCN data reported on Health eBlues.

Common Errors:

30. **Are 'unable to match member' errors something that will be common moving forward?**
    Membership lags, usually at open enrollment time, and there is a further lag for the downstream systems but that should not translate to a huge member not found for any specific PO. If there is a concern on the part of a PO we need to take a sample of the members and interrogate on the membership system. If you are getting large numbers of member not found in Production this could be a different issue. It can take a couple of months for us to get new members in our database.

31. **IT Testing Error Code 02: Has a missing CPT, Revenue or Service code for record type 'S' service. Errors appear to be related to well visits submitted by PO with a qualifying diagnosis code only. Is there another record type that is more appropriate for services in which the qualifying code is a diagnosis code?**
    The Blues will make note of the request for process improvement.

32. **IT File Testing Error Code 06: Invalid/Missing servicing provider for diabetic eye exam, nephrology visit or well-child visit/12-Invalid/missing provider for glaucoma screening. Can you clarify why these would have been flagged?**
    If you are submitting the service_type_cd, then please leave the diagnosis field blank. The Blues will make note of the request for process improvement as POs want to be able to send diagnosis codes.

33. **IT File Testing Error Code 07: Unable to match Member – MEME_CK: I believe this is an error on our part, submitting per-member ID instead of contract number for BCBSM patients. To ensure we fix it correctly can you confirm that contract number should be used for BCBSM patients and not per_memberID?**
    Correct, do not use the "Per_MemberID". Instead use "ContractNumberAlt" as this is a de-identified number. If not available, then use "ContractNumber".

COMMON TESTING ERRORS:

- Incorrect naming file convention
  - Auto sweep will miss files with incorrect names, no alert sent to it, file sits
  - Naming convention is on checklist
    - TEST_OriginId_EMR_SUPPLEMENTAL_INFO_yyyymmddhhmm
- Incorrect header rows
  - The header record format is provided on the "Header Row" worksheet
  - The header record consists of - ORIGIN_ID, FILE_CREATION_DT , and RECORD_CT field
  - The RECORD_CT field is used to perform this file level validation
- Date formatting
- Text in numerical fields

TIPS:

Tips on how to submit the data:

The following are some lessons learned from our supplemental information process pilot:

b. Please include leading/trailing zeroes in the member contract field (text field, not numeric).
c. The file format must be pipe delimited and include the PO ID in every record.
d. Please follow the header record layout for content to ensure appropriate BCN/BCBSM processing.
e. Please include all applicable diagnosis codes in your file submission.

- Use the "Checklist_EMRDMRFileTesting_September2013" to double check your test file before you send it to BCBSM.

- Use the "Checklist for Testing for Non-BCN POs and May EMR Release" as an additional resource.

- Pay special attention to date formats
  - Naming Convention: yyyymmddhhmm
  - File Creation Date and all dates within record: DD-MMM-YYYY (all records will have same creation date