



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE REGULATION
DEPARTMENT OF LABOR & ECONOMIC GROWTH
KEITH W. COOLEY, DIRECTOR

KEN ROSS
COMMISSIONER

July 7, 2008

MEMORANDUM

To: Health Care Providers, BCBSM Subscribers, Interest Groups,
and Other Interested Parties

From: Susan M. Scarane^{SMS}
Health Plans Division

Subject: Public Input on Blue Cross Blue Shield of Michigan's
Nurse Specialists Provider Class Plan

Under 1980 P.A. 350, as amended, the Nonprofit Health Care Corporation Reform Act (Act), Blue Cross Blue Shield of Michigan (BCBSM) must develop and maintain a "provider class plan" for each type of health care provider that provides services to BCBSM subscribers. A provider class plan must include a description of the reimbursement arrangement used by BCBSM to pay providers; measurable objectives for meeting the access, quality of care, and cost goals specified by Section 504 of the Act; and, in the case of those providers with which BCBSM contracts, a copy of the provider contract. Each plan must also show how BCBSM proposes to balance the goals stated above.

Attached is a copy of Order No. 08-032-BC, dated July 7, 2008, providing notice of intent to make a determination on the nurse specialists provider class plan, pursuant to Section 509(2) of the Act. BCBSM's nurse specialists provider class plan filed on August 3, 2003 and the modifications to the nurse specialists provider class plan filed by BCBSM on August 31, 2006 will be the subject of this review. These provider class plan documents are available at the OFIR website at www.michigan.gov/ofis.

Section 505(2) of the Act requires that the Commissioner of Financial and Insurance Regulation (OFIR) establish a procedure to gain input into the review and development of provider class plans prepared by BCBSM. Attachment A to the Order For Notice of Intent to Review contains a list of questions pertaining to the nurse specialists provider class plan. We would appreciate any comments you may have with respect to these questions or any other matters concerning the nurse specialists provider class plan.

Written testimony will be accepted through October 6, 2008, when mailed, faxed or e-mailed to:

Office of Financial and Insurance Regulation
Health Plans Division
Attention: Susan M. Scarane
P. O. Box 30220
Lansing, MI 48909
Fax: (517) 241-4168
E-mail: scaranes@michigan.gov

BCBSM is required to file an annual report for each provider class with the Commissioner of Financial and Insurance Regulation regarding the level of achievement of the above-mentioned goals. Pursuant to Section 517 of the Act, these reports need to include the data necessary to make a determination of BCBSM's compliance or noncompliance with the goals and compliance with objectives contained in each provider class plan. BCBSM's 2006-2007 annual report for the nurse specialists provider class is available at the OFIR website at www.michigan.gov/ofis.

If you prepare and distribute a newsletter or other publication, I would ask that you include information about the opportunity to provide written testimony on BCBSM's nurse specialists provider class plan in any such publication for the benefit of your readership. All of the BCBSM materials identified in this memorandum are available at the OFIR website at www.michigan.gov/ofis or you may obtain a copy of these documents by contacting Shannon Moreno at (517) 241-4549. Thank you for your assistance in this regard.

If you have any questions regarding the above referenced matter, please contact me at (517) 335-2052.

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner

In the matter of notice of intent to make a
determination with respect to the Nurse
Specialists Provider Class Plan of Blue Cross
Blue Shield of Michigan pursuant to Section
509(2) of PA 350 of 1980

No. 08-032-BC

Issued and entered
this 7th day of July 2008
by Ken Ross
Commissioner

**ORDER FOR NOTICE OF
INTENT TO REVIEW**

I

BACKGROUND

Section 509(1) of PA 350 of 1980, as amended (Act), being MCL 550.1101 et seq.; MSA 24.660 (101) et seq., allows the Commissioner of Insurance and Financial Regulation (Commissioner) to determine whether the arrangements Blue Cross Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the cost, access and quality of care goals set forth in the Act.

The Commissioner is required to evaluate enough BCBSM provider class plans to account for at least 75% of the corporation's provider payments during a 3-year period. The latest 3-year period began on January 1, 2007 and ends December 31, 2009. The Commissioner intends to review the provider class plan for nurse specialists at this time.

Section 509(2) of the Act requires the Commissioner to give written notice to BCBSM, and to each person who has requested a copy of such notice, of his intent to make a determination with respect to the provider class plans filed by BCBSM. Section 509(2) grants the Commissioner six months in which to reach his determinations.

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Section 505(2) of the Act requires the Commissioner to establish and implement procedures whereby any person, including a subscriber, may offer advice and consultation on the development, modification, implementation, or review of provider class plans.

In addition to the requirement to gain input on the review and development of provider class plans, there is need to establish an accurate record of the comments presented to the Commissioner. The record can then serve as part of the basis for the determinations that will be made by the Commissioner with regard to BCBSM's achievement of the goals of Section 504.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations, it is FOUND and CONCLUDED that:

1. Pursuant to Section 509(2) of the Act, the Commissioner shall give written notice to BCBSM, and to each person who has requested a copy of such notice, that he intends to make a determination with respect to a particular provider class plan. The Commissioner shall have 6 months in which to reach a determination.
2. Pursuant to Section 505(2) of the Act, the Commissioner must establish a procedure to gain input into the review and development of provider class plans prepared by BCBSM. The statute is silent as to the method chosen by the Commissioner to fulfill this responsibility.
3. The procedure established by the Commissioner should facilitate the presentation of information by any person and encourage input.

III

ORDER

Therefore, it is ORDERED that:

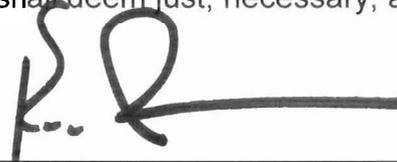
1. A determination shall be made with respect to the nurse specialists provider class plan. The evaluation period shall include calendar years 2006 and 2007. A determination with respect to the nurse specialists provider class plan will be made by January 7, 2009.
2. This order shall serve as notice of intent to make a determination with respect to the above stated provider class plan pursuant to Section 509(2) of the Act.

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3. Questions of interest pertaining to the nurse specialists provider class plan are included in Attachment A. Pursuant to Section 505(2), written comments will be accepted with regard to these questions or any other matters concerning the nurse specialists provider class plan through October 6, 2008, when sent to:

Office of Financial and Insurance Regulation
Health Plans Division
Attention: Susan M. Scarane
P. O. Box 30220
Lansing, MI 48909

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further Order or Orders, as he shall deem just, necessary, and appropriate.

A handwritten signature in black ink, appearing to be 'K. Ross', written over a horizontal line.

Ken Ross
Commissioner

**BLUE CROSS BLUE SHIELD OF MICHIGAN
NURSE SPECIALISTS PROVIDER CLASS PLAN
QUESTIONS OF INTEREST
JULY 7, 2008**

ACHIEVEMENT OF STATUTORY GOALS

The Office of Financial and Insurance Regulation needs to answer the following questions to determine whether Blue Cross Blue Shield of Michigan's (BCBSM) provider contracts and reimbursement arrangements for nurse specialists (certified nurse anesthetists, certified midwives and certified nurse practitioners) have met the access, quality and cost goals specified in Section 504 of the Act:

1. Does BCBSM have participation agreements with an appropriate number of nurse specialists throughout Michigan to assure that each subscriber has access to covered services?
2. Has BCBSM established and maintained reasonable standards of health care quality for participating nurse specialists?
3. Do the reimbursement arrangements for nurse specialists assure that the rate of change in BCBSM payment per member to those providers is not higher than the compound rate of inflation and real economic growth?

The Commissioner needs to consider the overall balance of the goals achieved by BCBSM under the nurse specialists provider class plan. Weight is to be given to each of the 3 statutory goals so that one goal is not focused on independently of the other statutory goals. Comments on how achievement of these goals can best be measured and evaluated will assist the Commissioner in making a determination.

ACHIEVEMENT OF BCBSM'S OBJECTIVES

BCBSM must include objectives in each provider class plan. These are expected achievement levels for the goals of reasonable access, cost and quality of health care services. The Office of Financial and Insurance Regulation needs to also determine whether BCBSM has achieved the objectives contained in the nurse specialists provider class plan and how the objectives relate to the statutory goals. Comments regarding the appropriateness and importance of BCBSM's objectives will assist the Office of Financial and Insurance Regulation in making these determinations.

A. ACCESS:

The BCBSM access objectives in the nurse specialists provider class plan under review are:

BCBSM – Nurse Specialists

Questions of Interest

Page 2

- Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeal processes, BCBSM's record keeping requirements and the participation agreement and its administration
- Maintain and periodically update a printed or Web site directory of participating providers

What types of information and data should the Office of Financial and Insurance Regulation examine to determine whether or not BCBSM has met its access objective?

Would meeting BCBSM's access objective be sufficient to assure that cost effective, quality services provided by nurse specialists are available, throughout the state, to BCBSM subscribers?

B. QUALITY OF CARE:

The BCBSM objectives in the nurse specialists provider class plan under review are:

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- Meet with specialty liaison societies to discuss issues of interest and concern
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes and disputes regarding utilization review audits

What types of information and data should the Office of Financial and Insurance Regulation examine to determine whether BCBSM has met its quality of care objective?

Would meeting BCBSM's quality of care objective be sufficient to assure that nurse specialists actually meet and abide by reasonable standards of health care quality? Is it also necessary or desirable to consider:

1. Whether BCBSM has satisfactorily recognized changes that have taken place in the health care industry?



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Nurse Specialists Provider Class Plan

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PROVIDER CLASS

A provider class may include health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the services for which reimbursement will be made may differ for the types of providers within a provider class.

Definition

The nurse specialists provider class is composed of certified nurse midwives, certified nurse practitioners and certified registered nurse anesthetists licensed in Michigan as registered nurses with specialty certification status issued by the Michigan Board of Nursing.

Covered Services

CNMs are limited to basic antepartum care, normal vaginal deliveries and postpartum care. CNMs are reimbursed for deliveries only when the delivery occurs in the inpatient hospital setting, or in a hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital.

CNPs are reimbursed for a broad range of services including complete physicals, health assessments, treatment of common acute illnesses and chronic stable medical conditions, and psychiatric services.

CRNAs are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities.

PA 350 GOALS AND OBJECTIVES

Provider class plans are developed and maintained pursuant to section 504 of PA 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

Cost Goal

“Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.” The goal is derived through the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where “I” means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the two calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where “REG” means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the four calendar years immediately preceding the year in which the commissioner's determination is being made.

Objectives

- ◆ Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions
- ◆ Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participation agreement
- ◆ Make a good-faith effort to enforce the per-claim participation provision in Section 502(1)(b) of PA 350 by responding to all inquiries and complaints

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Objective

- ◆ Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members
- ◆ Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participation agreement and its administration
- ◆ Maintain and periodically update a printed or Web site directory of participating providers

Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Objectives

- ◆ Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- ◆ Meet with specialty liaison societies to discuss issues of interest and concern
- ◆ Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes and disputes regarding utilization review audits

BCBSM POLICIES AND PROGRAMS

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

Covered services rendered by nurse specialists who do not participate, either formally or on a per-claim basis, are payable to the member.

Participation Policy

Certified Nurse Midwives

CNMs may choose to participate on either a formal or per-claim basis. Their participation agreement requires them to do many things, such as meet BCBSM's qualification standards, abide by BCBSM policies and accept BCBSM's payment as payment in full for all covered services, except for copayments and deductibles identified in members' certificates.

CNMs participating on a per-claim basis must accept BCBSM payment as payment in full "for all cases involving the procedure specified, for the duration of the calendar year" [PA 350, Section 502(1)(b)]. In addition, CNMs participating on a per-claim basis will be bound by the terms and conditions of the Certified Nurse Midwife Participation Agreement with respect to the claims on which they participate per-claim. CNMs participating on a per-claim basis must also meet performance standards that apply to formally participating CNMs.

Certified Nurse Practitioners

CNPs may only participate on a formal basis with BCBSM. Their participation agreement requires them to do many things, such as meet BCBSM's qualification standards, abide by BCBSM policies and accept BCBSM's payment as payment in full for all covered services, except for copayments and deductibles identified in members' certificates.

Certified Registered Nurse Anesthetists

CRNAs may choose to participate on either a formal or per-claim basis. Their participation agreement requires them to do many things, such as meet BCBSM's qualification standards, abide by BCBSM policies and accept BCBSM's payment as payment in full for all covered services, except for copayments and deductibles identified in members' certificates.

CRNAs participating on a per-claim basis must accept BCBSM payment as payment in full "for all cases involving the procedure specified, for the duration of the calendar year" [Michigan Public Act 350, Section 502(1)(b)]. In addition, CRNAs participating on a per-claim basis will be bound by the terms and conditions of the Certified Registered Nurse Anesthetists Participation Agreement with respect to the claims on which they participate per-claim. CRNAs participating on a per-claim basis must also meet performance standards that apply to formally participating CRNAs.

Qualification Standards

All nurse specialists may apply to participate with BCBSM. Nurse specialists who participate formally or per-claim must meet basic standards in addition to the specific qualification standards that apply to their specialties. These basic standards include, but are not limited to:

- ◆ A current Michigan license* as a registered nurse
- ◆ Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review
- ◆ Absence of fraud and illegal activities
- ◆ Each nurse specialist must also meet the following additional standards that apply to their specialty. BCBSM reserves the right to update these standards as necessary to conform to the Michigan Board of Nursing's requirements without first amending this provider class plan.

Certified Nurse Midwives

A CNM must have and maintain:

- ◆ Current national certification by the American College of Nurse Midwives, American Midwifery Certification Board or another nationally recognized nurse midwife certifying entity recognized by the Michigan Board of Nursing
- ◆ Current nurse midwife specialty certification issued by the Michigan Board of Nursing

For CNMs performing deliveries, the following items are also required:

- ◆ Written confirmation of an established relationship for medical consultation, collaboration or referral with an obstetrician/gynecologist (OB/Gyn) or a qualified physician, if access to an OB/Gyn is not available. A qualified physician is an MD/DO such as a perinatologist, family practice physician or internist with a women's health practice that corresponds to that of the CNM. The OB/Gyn or otherwise qualified physician must have OB/Gyn admitting privileges at the hospital or hospital-affiliated birthing center where the CNM will practice.

* BCBSM verifies licensure regularly with the state of Michigan.

- ◆ Written confirmation of established privileges with hospital(s), or hospital-affiliated birthing center(s), or written confirmation of emergency and hospital admission arrangements with a consultant physician who has admitting privileges.

Certified Nurse Practitioners

A CNP must have and maintain:

- ◆ Current certification by a nationally recognized certifying entity recognized by the Michigan Board of Nursing. This presently includes the following:
 - ◆ American Nurses Credentialing Center
 - ◆ National Certification Corporation for the Obstetric/Gynecologic and Neonatal Nursing Specialties
 - ◆ Pediatric Nursing Certification Board
 - ◆ American Academy of Nurse Practitioners
 - ◆ Oncology Nursing Certification Corporation
- ◆ Current nurse practitioner specialty certification issued by the Michigan Board of Nursing

Certified Registered Nurse Anesthetics

A CRNA must have and maintain:

- ◆ Current national certification from the Council on Certification of Nurse Anesthetists or current recertification from the Council on Recertification of Nurse Anesthetists
 - ◆ Current nurse anesthetist specialty certification issued by the Michigan Board of Nursing *
- * Once a CRNA obtains specialty certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA received national certification from the Council on Certification of Nurse Anesthetists. This applies to newly certified CRNAs only. A recertified CRNA's participation contract will be effective on the date it is issued.

Departicipation Policy

A departicipation policy allows BCBSM to departicipate a provider after review and recommendation for departicipation by the BCBSM Audit and Investigations Subcommittee. This policy is described further in Addendum I of the CNM, CNP and CRNA Participation Agreements.

Member Sanctions

BCBSM will not apply any sanction to members receiving services from departicipated providers unless it is authorized to do so by an amendment to PA 350 or other appropriate authority.

Provider Programs

BCBSM strives to ensure members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs.

Communications and Education

BCBSM provides the following resources to communicate with and educate nurse specialists:

- ◆ The Record, a monthly BCBSM publication that communicates current information regarding billing guidelines, policy changes and other administrative issues.
- ◆ The BCBSM Web site and online manual provide information on how to do business with BCBSM including billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements and the participation agreements and their administration. BCBSM maintains and updates the Web site and manual as necessary.
- ◆ Continuing medical and nursing education seminars
- ◆ The liaison process provides a forum in which specialty societies can bring issues of concern to BCBSM's attention. The process can include meetings with specialty societies as well as contact with BCBSM representatives by telephone or e-mail.

Performance Monitoring

BCBSM ensures current licensure through a licensing verification process using the Michigan Department of Community Health Web site. This agency also sends BCBSM lapsed license electronic data files weekly. The files are compared to the BCBSM provider database to ensure providers are licensed.

Utilization review audits serve as a check and balance to ensure that services were medically necessary and paid within the scope of members' benefits.

Suspected fraudulent activity, reported to BCBSM by providers, members or BCBSM staff, is referred to Corporate and Financial Investigations for further investigation. If fraud or illegal activities are confirmed, BCBSM will report such providers to the Michigan Department of Labor and Economic Growth.

Appeals Process

BCBSM's appeals process allows providers the right to appeal adverse claim decisions and utilization review audit determinations. The process is described in Addendum E of the CNM, CNP and CRNA Participation Agreements.

Reimbursement Policies

BCBSM reimburses participating nurse specialists for covered services deemed medically necessary by BCBSM. Addendum A of each of the attached participation agreements describes the determination of medical necessity.

Covered Services

Nurse specialists are reimbursed for a variety of services that BCBSM considers them qualified and licensed to perform in accordance with benefits covered by member certificates.

Reimbursement Methods

The following definition applies to the reimbursement methods for all nurse specialists:

Billed Charge

The billed charge refers to the actual charge indicated on the claim form submitted by the provider.

The following definition applies to the reimbursement methods for CNMs and CNPs:

Maximum Payment Level

Most of the Maximum Payment Schedule is based on the Resource Based Relative Value System developed by the Centers for Medicare and Medicaid Services, in which services are ranked according to the resource costs needed to provide them.

The resource costs of the RBRVS system include physician time, training, skill, risk, procedure complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Other factors that may be used in setting maximum payment levels include comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM will give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level. BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

BCBSM reviews relative values and reimbursement levels periodically and may adjust them as necessary.

An alternative reimbursement arrangement is available to groups through the Medical Surgical 90 program. The MS-90 program increases reimbursement levels for purposes of reducing out-of-pocket payments in regions where participation rates are low.

Certified Nurse Midwives

For each covered service performed, BCBSM will pay the lesser of the billed charge or the maximum payment level for allowable procedures. Allowable procedures for CNMs are limited to basic antepartum care, normal vaginal deliveries and postpartum care.

CNMs are reimbursed for deliveries only when the delivery occurs in the inpatient hospital setting, or in a hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital.

Certified Nurse Practitioners

For each covered service performed, BCBSM will pay the lesser of the billed charge or 85 percent of the maximum payment level.

Certified Registered Nurse Anesthetists

Certified registered nurse anesthetists are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities. Services are only approved when personally performed within the CRNA's scope of practice.

BCBSM will pay the lesser of the billed charge or a fee based on an anesthesia formula less copays and deductibles. The fee is calculated by multiplying a regional conversion factor by the sum of time (in 15-minute units) plus anesthesia base units, which is then multiplied by a percentage factor. The percentage is 40 percent when the service is performed under the medical direction of a physician responsible for anesthesia services, and who is not the operating surgeon, and 85 percent when the service is performed without medical direction of a physician who is responsible for anesthesia services and who is not the operating surgeon. The calculation may be stated as:

Fee = [(# time units + ABUs) x BCBSM regional conversion factor] x percentage (that is, 40 percent or 85 percent)

ABUs are obtained from the Centers for Medicare & Medicaid Services; however, BCBSM retains the option to modify them at its discretion. The conversion factors used to derive the fees will be based on product and geographic area, with the goal of equalizing payment levels by geographic area over time.

Retroactive Payments

After a CRNA obtains Nurse Anesthetist Specialty Certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA initially received national certification from the Council on Certification of Nurse Anesthetists. Retroactive reimbursement is available only to CRNAs upon their initial certification. Covered

services rendered after national certification has been obtained will be reimbursed if the requirements of the members' benefit plan and the CRNA's contract with BCBSM have been met.

Member Hold Harmless Provisions

Participating CNMs, CNPs and CRNAs agree to accept BCBSM's payment as payment in full for covered services. Member copayments and deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. As outlined in Addendum G of the CNM, CNP and CRNA Participation Agreements, participating CNMs, CNPs and CRNAs must hold members harmless from the following:

- ◆ Balance billing for covered services
- ◆ Liability for services that are not covered because they are not medically necessary or are experimental unless the member agrees in writing to pay for the services before they are provided
- ◆ Liability for covered services provided but not billed to BCBSM within a prescribed time frame

NURSE SPECIALIST PARTICIPATION AGREEMENTS (Attached)

- ◆ Certified Nurse Midwife Participation Agreement
- ◆ Certified Nurse Practitioner Participation Agreement
- ◆ Certified Registered Nurse Anesthetist Participation Agreement



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Nurse Specialists Provider Class Plan

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PROVIDER CLASS

A provider class may include health care facilities or health care professionals who have a reimbursement arrangement or provider contract with BCBSM to render services to BCBSM's members. Qualification standards and the scope of services for which reimbursement will be made may differ for the types of providers within a provider class.

Definition

The nurse specialists provider class is composed of certified nurse midwives, certified nurse practitioners and certified registered nurse anesthetists licensed in Michigan as registered nurses with specialty certification status issued by the Michigan Board of Nursing.

Scope of Services

CNMs are limited to basic antepartum care, normal vaginal deliveries and postpartum care. CNMs are reimbursed only for deliveries that occur in the inpatient hospital setting or a birthing center that is hospital-affiliated, state-licensed and accredited, as defined and approved by BCBSM.

CNPs are reimbursed for a broad range of services including complete physicals, health assessments, treatment of common acute illnesses and chronic stable medical conditions, health counseling, patient advocacy and psychiatric services.

CRNAs are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities.



PA 350 GOALS AND OBJECTIVES

Cost Goal

“Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.” The goal is derived through the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where “I” means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the two calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where “REG” means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the four calendar years immediately preceding the year in which the commissioner's determination is being made.

Objectives

1. Strive toward limiting the increase in total nurse specialists payments per member to the compound rate of inflation and real economic growth, as specified in PA 350, giving consideration to Michigan and national health care market conditions.
2. Provide equitable reimbursement to nurse specialists, in return for high quality services that are medically necessary and delivered to BCBSM subscribers at a reasonable cost.
3. Make a good-faith effort to enforce the per claim participation provision in Section 502(1)(b) of Public Act 350 through audit, provider inquiry and provider consultant activities, and by responding to all complaints.

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Objective

1. Ensure adequate availability of high-quality medical services, throughout the state, at a reasonable cost to BCBSM subscribers.

Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Objectives

1. Ensure the provision of quality care to BCBSM subscribers by requiring that nurse specialists meet qualification and performance standards in order to participate with BCBSM.
2. Maintain appropriate provider communication channels, as necessary, to explain billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements and the participation agreement and its administration.



BCBSM POLICIES AND PROGRAMS

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

BCBSM may issue a participating contract that covers all members of a provider class or it may offer a separate and individual contract on a per-claim basis, if applicable to the provider class.

Covered services rendered by nurse specialists who do not participate, either formally or on a per-claim basis, are payable to the member.

Participation Policy

CERTIFIED NURSE MIDWIVES

CNMs may choose to participate on either a formal or per-claim basis with BCBSM. Formally participating CNMs agree to accept BCBSM reimbursement as payment in full for all covered services provided, except for copays and deductibles specified in the member's certificate.

CNMs participating on a per-claim basis must accept BCBSM payment as payment in full "for all cases involving the procedure specified, for the duration of the calendar year" [Michigan Public Act 350, Section 502(1)(b)]. In addition, CNMs participating on a per-claim basis will be bound by the terms and conditions of the Certified Nurse Midwife Participation Agreement with respect to the claims on which they participate per claim. CNMs participating on a per-claim basis must also meet standards of professional performance that apply to formally participating CNMs.

CERTIFIED NURSE PRACTITIONERS

CNPs may only participate on a formal basis with BCBSM. Formally participating CNPs agree to accept BCBSM reimbursement as payment in full for all covered services provided, except for copays and deductibles specified in the members' certificate.

CERTIFIED REGISTERED NURSE ANESTHETISTS

CRNAs may choose to participate on either a formal or per-claim basis with BCBSM. Formally participating CRNAs agree to accept BCBSM reimbursement as payment in full for all covered services provided, except for copays and deductibles specified in the member's certificate. CRNAs participating on a per-claim basis must accept BCBSM payment as payment in full "for all cases involving the procedure specified, for the duration of the calendar year" [Michigan Public Act 350, Section 502(1)(b)]. In addition, CRNAs participating on a per-claim basis will be bound by the terms and conditions of the Certified Registered Nurse Anesthetists Participation Agreement with respect to the claims on which they participate per-claim. CRNAs participating on a per-claim basis must also meet standards of professional performance that apply to formally participating CRNAs.

Qualification Standards

Nurse specialists who participate formally or per-claim must meet basic standards in addition to the specific qualification standards that apply to their specialties. These basic standards include, but are not limited to:

- Licensure as a Registered Nurse from the state of Michigan
- Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review
- Absence of fraud and illegal activities

Current licensure is verified regularly with the state of Michigan.

Each nurse specialist must also meet the following additional standards that apply to their specialty. BCBSM reserves the right to update these standards as necessary to conform with the Michigan Board of Nursing's requirements without first amending this provider class plan.

CERTIFIED NURSE MIDWIVES

A CNM must have and maintain:

- Current national certification by the American College of Certified Nurse Midwives or another nationally recognized nurse midwife certifying entity recognized by the Michigan Board of Nursing
- Nurse Midwife Specialty Certification issued by the Michigan Board of Nursing
- Written confirmation of an established interdependent relationship, for medical consultation or collaboration or referral, to an obstetrician/ gynecologist (OB/Gyn) or to a qualified physician, if access to an OB/Gyn is not available. The physician, however, must have OB/Gyn admitting privileges at the hospital or hospital-affiliated birthing center where the CNM will practice. The CNM and physician will also establish a formal consultative arrangement with an OB/Gyn for quality assurance.

- Written confirmation of established privileges with hospital(s) or hospital-affiliated birthing centers
- Written practice protocols agreed upon by the certified nurse midwife and the physician with whom the CNM has an interdependent relationship

CERTIFIED NURSE PRACTITIONERS

A CNP must have and maintain:

- Current certification by a nationally recognized certifying entity recognized by the Michigan Board of Nursing. This presently includes the following:
 - American Nurses Credentialing Center
 - National Certification Corporation for the Obstetric/Gynecologic and Neonatal Specialties
 - National Certification Board of Pediatric Nurse Practitioners and Nurses
 - Nurse Practitioner Program of the U.S. Department of Health and Human Services
 - American Academy of Nurse Practitioners
 - The Oncology Nursing Certification Corporation
- Nurse Practitioner Specialty Certification issued by the Michigan Board of Nursing

CERTIFIED REGISTERED NURSE ANESTHETISTS

A CRNA must have and maintain:

- Current national certification from the Council on Certification of Nurse Anesthetists or current recertification from the Council on Recertification of Nurse Anesthetists
- Nurse Anesthetist Specialty Certification issued by the Michigan Board of Nursing *

* Once a CRNA obtains specialty certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA received national certification from the Council on Certification of Nurse Anesthetists. This applies to newly certified CRNAs only. A recertified CRNA's participation contract will be effective on the date it is issued.

Departicipation Policy

A departicipation policy allows BCBSM to departicipate a provider after review and recommendation for departicipation by the BCBSM Audit and Investigations Subcommittee. This policy is described further in Addendum I of the CNM, CNP and CRNA Participation Agreements.

Provider Programs

BCBSM strives to ensure the appropriateness and quality of the services delivered to subscribers through a combination of communication, education, and quality assurance programs that oversee and support health care providers.

Utilization Management Initiatives

Nurse specialists will be subject to audit and utilization management programs. BCBSM works to ensure that only medically necessary services are delivered to subscribers through the implementation of utilization management and quality assessment programs.

Education and Communications

The following resources will be available to nurse specialists in order to communicate and educate providers:

- Nurse specialists routinely receive The Record.
- BCBSM routinely plans and coordinates continuing medical education seminars.
- BCBSM meets with various specialty liaison societies to collaboratively discuss issues of interest and concern.

Performance Monitoring

- The provider credentialing process ensures that nurse specialists maintain state of Michigan licensure and national certification.
- Utilization review audits serve as a check and balance to ensure that services were medically necessary and paid within the scope of members' benefits.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers or BCBSM staff, is referred to Corporate Financial Investigations for further investigation.

Appeals Process

An appeals process that allows nurse specialists the right to appeal policy and non-policy issues made by BCBSM is described in Addendum E of the CNM, CNP and CRNA Participation Agreements. This explains: (1) a provider's right to a managerial-level conference under PA 350; (2) how the managerial-level conference process works and the timeframes involved under it; (3) when the PA 350 process can be invoked; and (4) how this process relates to the other processes described in the contract. This communication emphasizes that a managerial-level conference is a right guaranteed by law to every participating provider.

Reimbursement Policies

Reimbursement Methods

CERTIFIED NURSE MIDWIVES

For each covered service performed, BCBSM will pay the lesser of the billed charge or the maximum payment level for allowable procedures. Allowable procedures for CNMs are limited to basic antepartum care, normal vaginal deliveries and postpartum care.

Certified nurse midwives are reimbursed only for deliveries that occur in the inpatient hospital setting, or a birthing center that is hospital-affiliated, state-licensed and accredited as defined and approved by BCBSM.

CERTIFIED NURSE PRACTITIONERS

For each covered service performed in settings other than inpatient hospitals, BCBSM will pay the lesser of the billed charge or 85 percent of the maximum payment level.

Billed Charge

The billed charge refers to the actual charge indicated on the claim form submitted by the provider.

Maximum Payment

The maximum payment is based on the Centers for Medicare & Medicaid Services' resource based relative value scale, a schedule of relative procedure values which reflect the resource cost required to perform each service. The resources used in the RBRVS structure include time and work effort, specialty training, malpractice premiums and practice overhead. Values are assigned to each service in relation to the comparative value of all other services. The overall payment level under the RBRVS system is derived by multiplying the relative procedure value by a BCBSM-specific conversion factor, which is expressed in dollars and cents. The BCBSM board reviews payment levels at least annually.

CERTIFIED REGISTERED NURSE ANESTHETISTS

Certified registered nurse anesthetists are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities. Services are only approved when personally performed within the CRNA's scope of practice.

BCBSM will pay the lesser of the billed charge or a fee based on an anesthesia formula less copays and deductibles. The fee is calculated by multiplying a maximum dollar regional conversion factor by the sum of time (in 15-minute units) plus anesthesia base units, which is then multiplied by a percentage factor. The percentage is 40 percent when the service is performed under the medical direction of a physician responsible for anesthesia services and who is not the operating surgeon, and

85 percent when the service is performed without medical direction of a physician who is responsible for anesthesia services and who is not the operating surgeon. The calculation may be stated as:

Fee = [(# time units + ABUs) x BCBSM regional conversion factor] x percentage (that is, 40 percent or 85 percent)

ABUs are obtained from the Centers for Medicare & Medicaid Services; however, BCBSM retains the option to modify them at its discretion. The conversion factors used to derive the fees will be based on product and geographic area, with the goal of equalizing payment levels by geographic area over time.

Retroactive Payments

After a CRNA obtains Nurse Anesthetist Specialty Certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA initially received national certification from the Council on Certification of Nurse Anesthetists. Retroactive reimbursement is available only to CRNAs upon their initial certification. Covered services rendered after national certification has been obtained will be reimbursed if the requirements of the members' benefit plan and the CRNA's contract with BCBSM have been met.

Covered Services

Nurse specialists are reimbursed for a variety of services which they are qualified and licensed to perform. Payment for all services is based on medical necessity, which means that nurse specialists, acting on behalf of BCBSM, determine that the service is accepted as necessary and appropriate for the patient's condition and is not for the convenience of the member or physician. In the case of diagnostic testing, the tests are essential to and used in the diagnosis or management of the patient's condition.

Subscriber Hold Harmless Provisions

Participating CNMs, CNPs and CRNAs agree to accept BCBSM's payment as payment in full for covered services. Member copayments and deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. Participating CNMs, CNPs and CRNAs hold members harmless from:

- Balance billing, unless the services rendered are not covered services
- Medically necessary services, as determined by BCBSM, unless the member acknowledges BCBSM will not pay for the services and agrees in writing before the services are rendered to assume liability
- Financial obligation for covered services provided but not billed to BCBSM within a reasonable period except under those circumstances outlined in Addendum G of the CNM, CNP and CRNA Participation Agreements.



NURSE SPECIALIST PARTICIPATION AGREEMENTS

Certified Nurse Midwife Participation Agreement (Attached)

Certified Nurse Practitioner Participation Agreement (Attached)

Certified Registered Nurse Anesthetist Participation Agreement (Attached)

**BLUE CROSS AND BLUE SHIELD OF MICHIGAN
CERTIFIED NURSE MIDWIFE
PARTICIPATION AGREEMENT**

THIS AGREEMENT is made by and between Blue Cross and Blue Shield of Michigan (BCBSM) and the undersigned Certified Nurse Midwife (CNM or Provider), licensed in Michigan to provide health care services to Blue Cross or Blue Shield Plan members. This Agreement will be effective on the later of October 1, 2006 or the date accepted by BCBSM and will continue indefinitely unless terminated by either party under the terms set forth in Paragraph 21, below. Under this Agreement, CNM and BCBSM agree as follows:

1. BCBSM, or its representative, will make payment directly to CNM for covered services listed or limited in Blue Cross or Blue Shield Plan member certificates or benefit plan descriptions and which are within the scope of CNM's license and rendered by CNM, and which meet BCBSM Medical Necessity criteria as set forth in Addendum A.
2. BCBSM will pay CNM for covered services in accordance with the reimbursement methodology set forth in Addendum C.
3. BCBSM will process CNM's claims submitted in accordance with this Agreement in a timely fashion.
4. BCBSM will furnish to CNM a system and/or method for verification of eligibility and benefit coverages for members. This verification will be furnished as a service and not a guarantee of payment. CNM will make reasonable inquiry into the identity of the patient.
5. BCBSM will, without charge, supply CNM with BCBSM electronic access to guidelines and administrative information concerning billing requirements, benefits, utilization management and such other information as may be reasonably necessary for CNM to deliver covered services to members and be paid.
6. CNM will comply with the Qualification Standards established by BCBSM and agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without 60 days prior notice to CNM. The current Qualification Standards are set forth in Addendum B. Notice may be given in the appropriate provider publication (e.g. *The Record*).
7. BCBSM will maintain the confidentiality of CNM and member information and records, in accordance with applicable federal and state laws and the BCBSM Confidentiality Policy, as set forth in Addendum D.

BCBSM will indemnify and hold CNM harmless from any claims or litigation brought by members asserting breach of the BCBSM Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding CNM information and data, nor from communicating with customers, and hospitals regarding aggregated data pertaining to CNM and his/her peer group.

8. BCBSM will provide a reconsideration appeal mechanism for CNM in accordance with Addendum E, should CNM disagree with any claim adjudication or audit determination.
9. BCBSM will hold meetings with CNMs and physician representatives that will allow for ongoing review and discussion of issues that may arise under the Agreement.
10. BCBSM and CNM acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.
11. CNM certifies that all services billed or reported by CNM within the scope of CNM's license are performed personally by CNM, except as otherwise authorized and communicated by BCBSM, and are submitted in accordance with the terms and conditions of the members' certificates and/or benefit plan descriptions.
12. Except for copayments, deductibles and sanctions specified in members' certificates and/or benefit plan descriptions, CNM will accept BCBSM payment as full payment for covered services and for any 'out of panel' service rendered to a Blue Cross or Blue Shield preferred provider arrangement enrollee, and agrees not to collect any further payment from any member, except as set forth in Addendum G.
13. BCBSM represents that Blue Cross or Blue Shield Plan members, by contract, have authorized CNM to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. CNM will release patient information and records requested by BCBSM to enable it to process claims and for prepayment or postpayment review of medical records and equipment, as related to claims filed.
14. CNM will endeavor to file complete and accurate claims with BCBSM and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum F.
15. CNM agrees that a claim is neither payable by BCBSM nor a member if the claim is not filed with BCBSM within 180 days of the date of service, except as provided in Addendum G.
16. CNM agrees to the publication of his/her name, location and specialty to members.
17. CNM will adhere to BCBSM's policies and procedures regarding utilization review and quality assessment, precertification, case management or other programs established or modified by BCBSM, and will maintain records as set forth in BCBSM administrative policy. BCBSM agrees to furnish CNM with necessary information to enable CNM to adhere to BCBSM policy and procedure.
18. CNM agrees that BCBSM may review, photocopy and audit CNM's records as set forth in the attached Audit and Recovery Policy, Addendum H.
19. CNM understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services

and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

20. No contract modification or amendment will become effective until 90 days have elapsed from the date of BCBSM notice to CNM. Notice may be given in the appropriate BCBSM provider publication (e.g. *The Record*)
21. Either party may terminate this Agreement with or without cause. Without cause termination requires 60 days written prior notice by either party. For cause termination will be subject to BCBSM Deparicipation Policy as set forth in Addendum I and as thereafter modified by BCBSM.
22. Unless otherwise stated in this Agreement, any notice required or permitted under this Agreement shall be given in writing and sent to the other party at the following address or such other address as a party may designate from time to time.

If to Provider:

Current site address on
Provider File

If to BCBSM:

Provider Enrollment MC B443
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

23. In the event any portion of this Agreement is declared null and void by statute or ruling of a court of record or BCBSM's regulator, the remaining provisions of this Agreement will remain in full force and effect.
24. This Agreement is between CNM and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, CNM agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to CNM under this Agreement and no other obligations are created or implied by this language.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF

CNM 10-2006.doc

ADDENDA

- A. Medical Necessity Criteria
- B. Qualification Standards
- C. Reimbursement Methodology
- C. Confidentiality Policy
- D. Disputes and Appeals
- E. Service Reporting and Claims Overpayment Policy
- F. Services for Which Certified Nurse Midwives May Bill Members
- G. Audit and Recovery Policy
- H. Departicipation Policy

MEDICAL NECESSITY CRITERIA

Medical Necessity or Medically Necessary means a determination by BCBSM, based upon criteria and guidelines developed by professional providers, or professional review decisions that the service meets all of the following criteria:

- (a) it is generally accepted as necessary and appropriate for the patient's condition, given the symptoms, and is consistent with the diagnosis; and
- (b) it is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness and is not mainly for the convenience of the member or CNM; and
- (c) it is reasonably expected to improve the patient's condition or level of functioning or, in the case of diagnostic testing, results are actively used in the diagnosis and/or management of the patient's care.

QUALIFICATION STANDARDS

In order to participate with BCBSM, a Certified Nurse Midwife (CNM) must have and maintain all of the following:

- Current licensure by the state of Michigan as a Registered Nurse with Nurse Midwife specialty certification issued by the Michigan Board of Nursing.
- Current national certification by the American College of Nurse Midwives (ACNM), American Midwifery Certification Board or another nationally recognized nurse midwife certifying entity recognized by the Michigan Board of Nursing.

For CNMs performing deliveries, the following are also required:

- Written confirmation of an established relationship for medical consultation, collaboration or referral with an obstetrician/gynecologist (OB/Gyn) or a qualified physician, if access to an OB/Gyn is not available. A qualified physician is an MD/DO such as a perinatologist, family practice physician or internist with a women's health practice that corresponds to that of the CNM. The OB/Gyn or otherwise qualified physician must have OB/Gyn admitting privileges at the BCBSM participating hospital or BCBSM participating hospital-affiliated birthing center where the CNM will practice.
- Written confirmation of established privileges with hospital(s) and/or hospital-affiliated birthing center(s), or written confirmation of emergency and hospital admission arrangements with a consultant physician who has admitting privileges.
- Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review.
- Absence of fraud and illegal activities.

REIMBURSEMENT METHODOLOGY

For each covered service performed, BCBSM will pay CNM the lesser of billed charges or the amounts set forth in BCBSM's Maximum Payment Schedule. The Maximum Payment Schedule incorporates maximum payment levels which are based on the Health Care Finance Administration's (HCFA's) resource based relative value scale (RBRVS), a nationally derived schedule of procedure specific values, which reflect the resource use required to perform each service.

The resources used in the RBRVS structure include time and work effort, specialty training, professional liability insurance premium costs, and practice overhead expense. Values are assigned to each service in relation to the comparative value of all other services. The maximum payment level for each procedure is derived by multiplying the total relative value units (RVUs) for that procedure by a BCBSM conversion factor, which is expressed in dollars and cents.

For procedure codes which have no nationally derived RBRVS value, BCBSM will establish a maximum payment level by review and comparison to similar services.

BCBSM will review the Maximum Payment Schedule at least every 12 months to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Modifications to relative value assignments on individual procedure codes and nationally imposed changes to the nomenclature and national coding system for procedure codes which result in changes to the Maximum Payment Schedule will become effective upon notice to CNM. All other modifications to the reimbursement methodology or Maximum Payment Schedule will become effective 90 days from the date of notice by BCBSM to CNM. Notification of these modifications and changes will be provided by BCBSM publications or letters.

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of members and the confidentiality of personal data, personal information, and CNM financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. which requires BCBSM's Board of Directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of members and the confidentiality of personal data".

In adopting this policy, BCBSM acknowledges the rights of its members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; to know it will not be shared with others except for legitimate business purposes or in accordance with a member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a member, which is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a member, including an automated or computer accessible record, containing information such as address, age/birth date, Coordination of Benefits data, which is maintained or stored by a health care corporation.

The term "CNM financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain CNM financial data and information as confidential.

BCBSM will collect and maintain necessary member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to members will notify members of these routine uses and contain the member's consent to release data for these purposes. These forms will also advise the members of their rights under this policy.

Upon request, a member will be notified regarding the actual release of personal data.

BCBSM will not release member specific personal data except on a legitimate need to know basis or where the member has given specific authorization. Data released with the member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the member executes in writing another prior and specific informed consent authorizing the additional release. Where protected by specific statutory authority, member specific data will not be released without appropriate authorization.

Experience-rated and self-funded customers and other entities may obtain personal data and CNM financial data for auditing and other purposes provided that claims of identifiable members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to accounts and facilities will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

**APPEALS PROCESS FOR INDIVIDUAL CLAIMS DISPUTES AND UTILIZATION
REVIEW AUDIT DETERMINATIONS**

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Provider must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW

Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, Provider shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For individual claims disputes:

Provider Appeals Unit MC 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For disputes regarding professional provider utilization review audit results:

Manager, Professional Utilization Review MC J103
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of Provider's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If Provider is dissatisfied with the determination of the Written Complaint/Reconsideration Review, Provider may submit a written request for a Managerial-Level Review Conference. The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. Provider or his/her representative will normally be in attendance to present their case. The conference can be held by telephone if Provider prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:

Conference Coordination Unit MC 2027
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Conferences regarding professional utilization review audit results disputes:

Manager, Professional Utilization Review MC J103
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Managerial-Level Review Conference must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to Provider in writing within 30 days of the request for the Conference. The determination(s) of a Managerial-Level Review Conference delineate the following, as appropriate:

- 1) The proposed resolution;
- 2) The facts, along with supporting documentation, on which the proposed resolution was based.
- 3) The specific section or sections of the law, Certificate, contract or other written policy or document on which the proposed resolution is based;
- 4) A statement describing the status of each claim involved in the dispute; and

- 5) If the determination is not in concurrence with Provider's appeal, a statement explaining Provider's right to appeal the matter to the Michigan Office of Financial and Insurance Services with 120 days after receipt of BCBSM's written response to the Conference, as well as Provider's option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative or billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving issues of Medical Necessity that are resultant from medical record reviews, Provider may submit a written request for an External Peer Review if he/she is dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, Provider can request a review by an external peer review organization to review the medical record(s) in dispute. Provider will normally be notified of the determinations(s) made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon the provider and BCBSM.

If BCBSM's findings are upheld on appeal, Provider will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of Provider's right to appeal any Medical Necessity issues to the Office of Financial and Insurance Services or to initiate an action on those issues in a state court.

Provider's request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Manager, Professional Utilization Review MC J103
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Conference Coordination Unit MC 2027
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

INTERNAL REVIEW COMMITTEE

For disputes involving administrative and/or Billing & Coding issues, Provider may submit a written request for a review by the BCBSM Internal Review Committee (IRC) which is composed of three members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy(ies) in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM's response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. Provider, or his/her representative and upon Provider's written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Director, Utilization Management MC J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Provider is dissatisfied with the determination of the Internal Review Committee, he/she may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's board of directors) or directly to the Michigan Office of Financial and Insurance Services, or initiate an action in an appropriate state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Provider may, within 30 days receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee (PRC); a subcommittee of the BCBSM board of directors composed of BCBSM participating professionals, community leaders and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. Provider must represent itself at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

Director, Utilization Management MC J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Provider is dissatisfied with the determination of the Provider Relations Committee, he/she may appeal the determination to the Michigan Office of Financial and Insurance Services, or initiate an action in an appropriate state court.

MICHIGAN OFFICE OF FINANCIAL AND INSURANCE SERVICES

Informal Review & Determination

If Provider is dissatisfied with BCBSM's response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if Provider believes that BCBSM has violated a provision of either Section 402 or 403 of P.A. 350, Provider shall have the right to submit a request to the Michigan Office of Financial and Insurance Services for an Informal Review & Determination (IR&D).

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of P.A. 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Office of Financial and Insurance Services
Post Office Box 30220
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Office of Financial and Insurance Services. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Office of Financial and Insurance Services shall issue its determination.

Contested Case Hearing

If dissatisfied with the Office of Financial and Insurance Services' determination, either Provider or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Office of Financial and Insurance Services' Determination is mailed, and shall be mailed to the Office of Financial and Insurance Services at the same address found in the prior step.

CIVIL COURT REVIEW

Either Provider or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

STATE COURT SYSTEM

Also, as noted above, at any time after the completion of the Written Complaint/Reconsideration Review and Management Review Conference steps, Provider may attempt to resolve the dispute by initiating an action in the appropriate state court.

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Provider will furnish a claim or report to BCBSM in the form BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge, with complete and accurate information, including diagnosis with procedure codes approved by BCBSM, license number of reporting provider and such other information as may be required by BCBSM to adjudicate claims.

Provider will use a provider identification code acceptable to BCBSM for billing of covered services.

Provider agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for covered services by requesting information from members, including but not limited to information pertaining to workers' compensation, other group health insurance, third party liability and other coverages. Provider further agrees to identify those members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Provider is aware the patient has primary coverage with another third party payer or entity, Provider agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Provider shall promptly report overpayments to BCBSM discovered by Provider, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Provider or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where Provider appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, which ever occurs first. If audit refund recoveries and other overpayment obligations are fully repaid over the course of one month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.

**SERVICES FOR WHICH
CERTIFIED NURSE MIDWIFE MAY BILL MEMBER**

Provider may bill member for:

1. Noncovered services unless the service has been deemed a noncovered service solely as a result of a determination by BCBSM that the service was Medically Unnecessary or experimental, in which case Provider assumes full financial responsibility for the denied claims. Provider may bill the member for claims denied as Medically Unnecessary or experimental only as stated in paragraph 2, below;
2. Services determined by BCBSM to be Medically Unnecessary, where the member acknowledges that BCBSM will not make payment for such services, and the member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;
3. Covered services denied by BCBSM as untimely billed, if all of the following requirements are met:
 - a. Provider documents that a claim was not submitted to BCBSM within 180 days of performance of such services because a member failed to provide proper identifying information; and
 - b. Provider submits a claim to BCBSM for payment consideration within three months after obtaining the necessary information.

AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Blue Cross or Blue Shield Plan members' medical records or other pertinent records of Provider to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Provider for the reasonable copying expense incurred by Provider where Provider copies records requested by BCBSM in connection with BCBSM audit activities.

Provider shall prepare and maintain all appropriate records on all members receiving services, and shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to providers by BCBSM, and such requirements subsequently developed which are communicated to providers prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, Medical Necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the services rendered.

III. Time

BCBSM may conduct on-site audits during Provider's regular business hours. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not Medically Necessary as determined by BCBSM under Addendum A. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

DEPARTICIPATION POLICY

BCBSM policy establishes the mechanism, criteria and responsibility for deparicipating providers under Regular Business. Deparicipated providers will have claims subject to Prepayment Utilization Review and processed as non-par with payments directed to the members.

This policy provides for review and recommendation by the Audits and Investigations Subcommittee (AIS).

All BCBSM provider types and subspecialties within those provider categories are covered under this policy.

Criteria under which a provider may be recommended for deparicipation include, but are not limited to, providers who are determined to be involved in the inappropriate use or billing of services, providers who are convicted of fraudulent or criminal acts involving BCBSM, Medicare, Medicaid, or other third party carriers; providers who have had their licensure/certification/accreditation suspended or revoked in Michigan; providers who refuse access to records for audit purposes; and providers who are in violation of local, state or federal regulations, laws, codes, etc. (See Deparicipation Criteria).

Appeal requests must be submitted in writing by an executive representative of the Provider and/or his/her duly authorized representative.

The AIS will review the recommendation and make a determination regarding deparicipation of Provider. The deparicipation is effective upon notice to Provider. The AIS will receive any subsequent appeal.

The Opinion Review Board (ORB) will hear all provider related deparicipation appeals. The ORB determination may be appealed to the Provider Relations Committee (PRC) of the BCBSM Board of Directors.

The PRC hears appeals based only on the facts and findings of previous reviews. The PRC decision is the final level of the appellate process.

DEPARTICIPATION CRITERIA

Criteria under which a provider may be recommended for deparicipation include, but are not limited to, the following:

1. Any felony conviction or misdemeanor involving BCBSM, Medicare, Medicaid, and/or other health care insurers.
2. Termination or suspension of licensure, certification, registration, certificate of need, or accreditation in Michigan.
3. Providers who continue to be non-compliant in their reporting after documented notification.
4. Providers who, after notification, continue to bill patients for amounts in excess of deductibles and copayments.
5. Providers who, upon audit, fail to document the necessity of 50% or more of their audited services billed to BCBSM.
6. Providers identified as prescribing/dispensing controlled substances for other than therapeutic reasons.
7. Providers demonstrating a pattern of billing for services not rendered or not Medically Necessary.
8. Providers refusing access to records which are deemed essential for BCBSM to determine its liability.
9. Providers found to be inducing patients to receive services through the use of work slips, prescriptions, or money.
10. Providers advertising free service, then billing BCBSM additional services which are not medically indicated.
11. Provider who have identified refunds in excess of \$100,000.00.
12. Providers who are in violation of local, state or federal regulations, laws, codes, etc.,

**BLUE CROSS BLUE SHIELD OF MICHIGAN
CERTIFIED NURSE PRACTITIONER
PARTICIPATION AGREEMENT**

THIS AGREEMENT is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and the undersigned Certified Nurse Practitioner (CNP or Provider), licensed in Michigan to provide health care services to Blue Cross or Blue Shield Plan members. This Agreement will be effective on the later of October 1, 2006 or the date accepted by BCBSM and will continue unless terminated by either party under the terms set forth in Paragraph 21 below.

Under this Agreement, CNP and BCBSM agree as follows:

1. BCBSM, or its representative, will make payment directly to CNP for covered services listed or limited in Blue Cross or Blue Shield Plan member certificates or benefit plan descriptions and which are within the scope of CNP's license and rendered by CNP, and which meet BCBSM Medical Necessity criteria as set forth in Addendum A.
2. BCBSM will pay CNP for covered services in accordance with the reimbursement methodology set forth in Addendum C.
3. BCBSM will process CNP's claims submitted in accordance with this Agreement in a timely fashion.
4. BCBSM will furnish to CNP a system and/or method for verification of eligibility and benefit coverages for members. This verification will be furnished as a service and not a guarantee of payment. CNP will make reasonable inquiry into the identity of the patient.
5. BCBSM will, without charge, supply CNP with BCBSM guidelines and administrative information concerning billing requirements, benefits, utilization management and such other information as may be reasonably necessary for CNP to deliver covered services to members and be paid.
6. CNP will comply with the Qualification Standards established by BCBSM and agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without 60 days prior notice to CNP. The current Qualification Standards are set forth in Addendum B. Notice may be given in the appropriate BCBSM provider publication (e.g. *The Record*).
7. BCBSM will maintain the confidentiality of CNP and member information and records, in accordance with applicable federal and state laws and the BCBSM Confidentiality Policy, as set forth in Addendum D.

BCBSM will indemnify and hold CNP harmless from any claims or litigation brought by members asserting breach of the BCBSM Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries

and/or agents regarding CNP information and data, nor from communicating with customers regarding aggregated data pertaining to CNP and his/her peer group.

8. BCBSM will provide a reconsideration appeal mechanism for CNP in accordance with Addendum E, should CNP disagree with any claim adjudication or audit determination.
9. BCBSM will hold meetings with CNPs that will allow for ongoing review and discussion of issues that may arise under the Agreement.
10. BCBSM and CNP acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.
11. CNP certifies that all services billed or reported by CNP are within the scope of CNP's license and are performed personally by CNP, except as otherwise authorized and communicated by BCBSM, and are submitted in accordance with the terms and conditions of the members' certificates and/or benefit plan descriptions.
12. Except for copayments, deductibles and sanctions specified in Blue Cross or Blue Shield Plan members' certificates and/or benefit plan descriptions, CNP will accept BCBSM payment as full payment for covered services and for any 'out of panel' service rendered to a BCBSM preferred provider arrangement enrollee, and agrees not to collect any further payment from any member, except as set forth in Addendum G.
13. BCBSM represents that BCBSM members, by contract, have authorized CNP to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. CNP will release patient information and records requested by BCBSM to enable it to process claims and for pre-payment or post-payment review of medical records and equipment, as related to claims filed.
14. CNP will endeavor to file complete and accurate claims with BCBSM and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum F.
15. CNP agrees that a claim is neither payable by BCBSM nor a member if the claim is not filed with BCBSM within 180 days of the date of service, except as provided in Addendum G.
16. CNP agrees to the publication of his/her name, location and specialty to members.
17. CNP will adhere to BCBSM's policies and procedures regarding utilization review and quality assessment, precertification, case management or other programs established or modified by BCBSM, and will maintain records as set forth in BCBSM administrative policy. BCBSM agrees to furnish CNP with necessary information to enable CNP to adhere to BCBSM policy and procedure.

18. CNP agrees that BCBSM may review, photocopy and audit CNP's records as set forth in the attached Audit and Recovery Policy, Addendum H.
19. CNP understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.
20. No contract modification or amendment will become effective until 90 days have elapsed from the date of BCBSM notice to CNP. Notice may be given in the appropriate BCBSM provider publication (e.g., *The Record*).
21. Either party may terminate this Agreement with or without cause. Without cause termination requires 60 days written prior notice by either party. For cause termination will be subject to BCBSM Deparicipation Policy as set forth in Addendum I and as thereafter modified by BCBSM.
22. Unless otherwise stated in this Agreement, any notice required or permitted under this Agreement shall be given in writing and sent to the other party at the following address or such other address as a party may designate from time to time.

If to Provider:

Current site address on
BCBSM Provider File

If to BCBSM:

Provider Enrollment Department MC B443
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

23. In the event any portion of this Agreement is declared null and void by statute or ruling of a court of record or BCBSM's regulator, the remaining provisions of this Agreement will remain in full force and effect.
24. This Agreement is between CNP and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, CNP agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to CNP under this Agreement and no other obligations are created or implied by this language.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF

ADDENDA

- A. Medical Necessity Criteria
- B. Qualifications Standards
- C. Reimbursement Methodology
- D. Confidentiality Policy
- E. Disputes and Appeals
- F. Service Reporting and Claims Overpayment Policy
- G. Services for Which Providers May Bill Members
- H. Audit and Recovery Policy
- I. Departicipation Policy

MEDICAL NECESSITY CRITERIA

Medical Necessity is determined by providers. For purposes of payment by BCBSM, Medical Necessity or Medically Necessary means a determination by providers for BCBSM based upon criteria and guidelines developed by providers for BCBSM, or, in the absence of such criteria and guidelines, based upon provider review, in accordance with accepted medical standards and practices, that the service:

is accepted as necessary and appropriate for the patient's condition and is not mainly for the convenience of the member or Provider; and in the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.

QUALIFICATION STANDARDS

In order to participate with BCBSM, a Certified Nurse Practitioner (CNP) must have and maintain all of the following:

- Current licensure as a Registered Nurse by the state of Michigan with nurse practitioner specialty certification issued by the Michigan Board of Nursing.
- Current certification by a nationally recognized certifying entity recognized by the Michigan Board of Nursing. This presently includes the following:
 - American Nurses Credentialing Center
 - National Certification Corporation for the Obstetric/Gynecology and Neonatal Nursing Specialties
 - Pediatric Nursing Certification Board
 - American Academy of Nurse Practitioners
 - The Oncology Nursing Certification Program
- Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review.
- Absence of fraud and illegal activities.

REIMBURSEMENT METHODOLOGY

For each covered service performed, BCBSM will pay CNP the lesser of billed charges or 85% of the amount set forth in BCBSM's Maximum Payment Schedule. The Maximum Payment Schedule incorporates maximum payment levels which are based on the Health Care Finance Administration's (HCFA's) resource based relative value scale (RBRVS), a nationally derived schedule of procedure specific values, which reflect the resource use required to perform each service.

The resources used in the RBRVS structure include time and work effort, specialty training, professional liability insurance premium costs, and practice overhead expense. Values are assigned to each service in relation to the comparative value of all other services. The maximum payment level for each procedure is derived by multiplying the total relative value units (RVUs) for that procedure by a BCBSM conversion factor, which is expressed in dollars and cents.

For procedure codes which have no nationally derived RBRVS value, BCBSM will establish a maximum payment level by review and comparison to similar services.

BCBSM will review the Maximum Payment Schedule at least every 12 months to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Modifications to relative value assignments on individual procedure codes and nationally imposed changes to the nomenclature and national coding system for procedure codes which result in changes to the Maximum Payment Schedule will become effective upon notice to CNP. All other modifications to the reimbursement methodology or Maximum Payment Schedule will become effective 90 days from the date of notice by BCBSM to CNP. Notification of these modifications and changes will be provided by BCBSM publications or letters.

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of members and the confidentiality of personal data, personal information, and CNP financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. which requires BCBSM's Board of Directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of members and the confidentiality of personal data".

In adopting this policy, BCBSM acknowledges the rights of its members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; to know it will not be shared with others except for legitimate business purposes or in accordance with a member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a member, which is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a member, including an automated or computer accessible record, containing information such as address, age/birth date, Coordination of Benefits data, which is maintained or stored by a health care corporation.

The term "CNP financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain CNP financial data and information as confidential.

BCBSM will collect and maintain necessary member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to members will notify members of these routine uses and contain the member's consent to release data for these purposes. These forms will also advise the members of their rights under this policy.

Upon request, a member will be notified regarding the actual release of personal data.

BCBSM will not release member specific personal data except on a legitimate need to know basis or where the member has given specific authorization. Data released with the member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the member executes in writing another prior and specific informed consent authorizing the additional release. Where protected by specific statutory authority, member specific data will not be released without appropriate authorization.

Experience-rated and self-funded customers and other entities may obtain personal data and CNP financial data for auditing and other purposes provided that claims of identifiable members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to accounts and facilities will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

**APPEALS PROCESS FOR INDIVIDUAL CLAIMS DISPUTES AND UTILIZATION
REVIEW AUDIT DETERMINATIONS**

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Provider must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW

Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, Provider shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For individual claims disputes:

Provider Appeals Unit MC 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For disputes regarding professional provider utilization review audit results:

Manager, Professional Utilization Review MC J103
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of Provider's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If Provider is dissatisfied with the determination of the Written Complaint/Reconsideration Review, Provider may submit a written request for a Managerial-Level Review Conference. The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. Provider or his/her representative will normally be in attendance to present their case. The conference can be held by telephone if Provider prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:

Conference Coordination Unit MC 2027
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Conferences regarding professional utilization review audit results disputes:

Manager, Professional Utilization Review MC J103
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Managerial-Level Review Conference must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to Provider in writing within 30 days of the request for the Conference. The determination(s) of a Managerial-Level Review Conference delineate the following, as appropriate:

- 1) The proposed resolution;
- 2) The facts, along with supporting documentation, on which the proposed resolution was based.
- 3) The specific section or sections of the law, Certificate, contract or other written policy or document on which the proposed resolution is based;
- 4) A statement describing the status of each claim involved in the dispute; and

- 5) If the determination is not in concurrence with Provider's appeal, a statement explaining Provider's right to appeal the matter to the Michigan Office of Financial and Insurance Services with 120 days after receipt of BCBSM's written response to the Conference, as well as Provider's option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, or billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving issues of Medical Necessity that are resultant from medical record reviews, Provider may submit a written request for an External Peer Review if he/she is dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, Provider can request a review by an external peer review organization to review the medical record(s) in dispute. Provider will normally be notified of the determinations(s) made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon the provider and BCBSM.

If BCBSM's findings are upheld on appeal, Provider will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of Provider's right to appeal any Medical Necessity issues to the Office of Financial and Insurance Services or to initiate an action on those issues in a state court.

Provider's request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Manager, Professional Utilization Review MC J103
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Conference Coordination Unit MC 2027
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

INTERNAL REVIEW COMMITTEE

For disputes involving administrative and/or Billing & Coding issues, Provider may submit a written request for a review by the BCBSM Internal Review Committee (IRC) which is composed of three members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy(ies) in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM's response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. Provider, or his/her representative and upon Provider's written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Director, Utilization Management MC J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Provider is dissatisfied with the determination of the Internal Review Committee, he/she may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's board of directors) or directly to the Michigan Office of Financial and Insurance Services; or initiate an action in an appropriate state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Provider may, within 30 days receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee (PRC); a subcommittee of the BCBSM board of directors composed of BCBSM participating professionals, community leaders and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. Provider must represent itself at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

Director, Utilization Management MC J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Provider is dissatisfied with the determination of the Provider Relations Committee, he/she may appeal the determination to the Michigan Office of Financial and Insurance Services, or initiate an action in an appropriate state court.

MICHIGAN OFFICE OF FINANCIAL AND INSURANCE SERVICES

Informal Review & Determination

If Provider is dissatisfied with BCBSM's response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if Provider believes that BCBSM has violated a provision of either Section 402 or 403 of P.A. 350, Provider shall have the right to submit a request to the Michigan Office of Financial and Insurance Services for an Informal Review & Determination (IR&D).

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of P.A. 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Office of Financial and Insurance Services (OFIS)
Post Office Box 30220
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Office of Financial and Insurance Services. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Office of Financial and Insurance Services shall issue its determination.

Contested Case Hearing

If dissatisfied with Office of Financial and Insurance Services' determination, either Provider or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Office of Financial and Insurance Services' determination is mailed, and shall be mailed to Office of Financial and Insurance Services at the same address found in the prior step.

CIVIL COURT REVIEW

Either Provider or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

STATE COURT SYSTEM

Also, as noted above, at any time after the completion of the Written Complaint/Reconsideration Review and Management Review Conference steps, Provider may attempt to resolve the dispute by initiating an action in the appropriate state court.

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Provider will furnish a claim or report to BCBSM in the form BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge, with complete and accurate information, including diagnosis with procedure codes approved by BCBSM, license number of reporting provider and such other information as may be required by BCBSM to adjudicate claims.

Provider will use a provider identification code acceptable to BCBSM for billing of covered services.

Provider agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for covered services by requesting information from members, including but not limited to information pertaining to workers' compensation, other group health insurance, third party liability and other coverages. Provider further agrees to identify those members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Provider is aware the patient has primary coverage with another third party payer or entity, Provider agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Provider shall promptly report overpayments to BCBSM discovered by Provider, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Provider or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where Provider appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, which ever occurs first. If audit refund recoveries and other overpayment obligations cannot be fully repaid over the course of one month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.

**SERVICES FOR WHICH
CERTIFIED NURSE PRACTITIONER MAY BILL MEMBER**

Provider may bill member for:

1. Noncovered services unless the service has been deemed a noncovered service solely as a result of a determination by BCBSM that the service was Medically Unnecessary or experimental, in which case Provider assumes full financial responsibility for the denied claims. Provider may bill the member for claims denied as Medically Unnecessary or experimental only as stated in paragraph 2, below;
2. Services determined by BCBSM to be Medically Unnecessary, where the member acknowledges that BCBSM will not make payment for such services, and the member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;
3. Covered services denied by BCBSM as untimely billed, if all of the following requirements are met:
 - a. Provider documents that a claim was not submitted to BCBSM within 180 days of performance of such services because a member failed to provide proper identifying information; and
 - b. Provider submits a claim to BCBSM for payment consideration within three months after obtaining the necessary information.

AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Blue Cross or Blue Shield Plan members' medical records or other pertinent records of Provider to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Provider for the reasonable copying expense incurred by Provider where Provider copies records requested by BCBSM in connection with BCBSM audit activities.

Provider shall prepare and maintain all appropriate records on all members receiving services, and shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to providers by BCBSM, and such requirements subsequently developed which are communicated to providers prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, Medical Necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the services rendered.

III. Time

BCBSM may conduct on-site audits during Provider's regular business hours. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not Medically Necessary as determined by BCBSM under Addendum A. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

DEPARTICIPATION POLICY

BCBSM policy establishes the mechanism, criteria and responsibility for deparicipating providers under Regular Business. Deparicipated providers will have claims subject to Prepayment Utilization Review and processed as non-par with payments directed to the members.

This policy provides for review and recommendation by the Audits and Investigations Subcommittee (AIS).

All BCBSM provider types and subspecialties within those provider categories are covered under this policy.

Criteria under which a provider may be recommended for deparicipation include, but are not limited to, providers who are determined to be involved in the inappropriate use or billing of services, providers who are convicted of fraudulent or criminal acts involving BCBSM, Medicare, Medicaid, or other third party carriers; providers who have had their licensure/certification/accreditation suspended or revoked in Michigan; providers who refuse access to records for audit purposes; and providers who are in violation of local, state or federal regulations, laws, codes, etc. (See Deparicipation Criteria).

Appeal requests must be submitted in writing by an executive representative of the Provider and/or his/her duly authorized representative.

The AIS will review the recommendation and make a determination regarding deparicipation of Provider. The deparicipation is effective upon notice to Provider. The AIS will receive any subsequent appeal.

The Opinion Review Board (ORB) will hear all provider related deparicipation appeals. The ORB determination may be appealed to the Provider Relations Committee (PRC) of the BCBSM Board of Directors.

The PRC hears appeals based only on the facts and findings of previous reviews. The PRC decision is the final level of the appellate process.

DEPARTICIPATION CRITERIA

Criteria under which a provider may be recommended for deparicipation include, but are not limited to, the following:

1. Any felony conviction or misdemeanor involving BCBSM, Medicare, Medicaid, and/or other health care insurers.
2. Termination or suspension of licensure, certification, registration, certificate of need, or accreditation in Michigan.
3. Providers who continue to be non-compliant in their reporting after documented notification.
4. Providers who, after notification, continue to bill patients for amounts in excess of deductibles and copayments.
5. Providers who, upon audit, fail to document the necessity of 50% or more of their audited services billed to BCBSM.
6. Providers identified as prescribing/dispensing controlled substances for other than therapeutic reasons.
7. Providers demonstrating a pattern of billing for services not rendered or not Medically Necessary.
8. Providers refusing access to records which are deemed essential for BCBSM to determine its liability.
9. Providers found to be inducing patients to receive services through the use of work slips, prescriptions, or money.
10. Providers advertising free service, then billing BCBSM additional services which are not medically indicated.
11. Provider who have identified refunds in excess of \$100,000.00.
12. Providers who are in violation of local, state or federal regulations, laws, codes, etc.,

**BLUE CROSS BLUE SHIELD OF MICHIGAN
CERTIFIED REGISTERED NURSE ANESTHETIST
PARTICIPATING AGREEMENT**

THIS AGREEMENT is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and the undersigned Certified Registered Nurse Anesthetist (CRNA).

Pursuant to this Agreement, CRNA and BCBSM agree as follows:

**ARTICLE I
DEFINITIONS**

For purposes of this Agreement, defined terms are:

- 1.1. **"Agreement"** means this Agreement, and all exhibits and Addenda attached hereto, or other documents specifically referenced and incorporated herein.
- 1.2. **"Alternative Delivery System"** (ADS) means any preferred provider organization, health maintenance organization, point of service or other than traditional delivery systems owned, controlled, administered or operated in whole or in part, by BCBSM or its subsidiaries, which have elected to participate in the CRNA Direct Reimbursement Program, or by any other Blue Cross and/or Blue Shield (BCBS) Plan.
- 1.3. **"BCBS Plans"** means organizations which are licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and/or Blue Shield names and service marks. Unless otherwise specified, the term BCBS Plans includes BCBSM.
- 1.4. **"Certificate"** means benefit plan descriptions under the sponsorship of BCBSM or other Blue Cross and Blue Shield Plans, or certificates and riders issued by or under their sponsorship, or arrangements with any employer group, including any self-funded plan, where BCBSM or other BCBS Plans administer benefits. For purposes of this Agreement only, "sponsorship" includes any Alternative Delivery System(s).
- 1.5. **"Covered Services"** means those anesthesia services which are: (i) listed or provided for in Certificates, (ii) Medically Necessary as set forth in Addendum "A", (iii) within the CRNA's scope of license, (iv) are provided personally by the CRNA, and (v) performed in an approved setting. For purposes of this Agreement, "Approved Settings" are; Peer Group 1-4 hospitals, Ambulatory Surgery Facilities (ASFs) that are licensed as Freestanding Surgical Outpatient Facilities in Michigan, and Peer Group 5 hospitals *if* the CRNA service is not included in BCBSM's facility payment to the hospital.
- 1.6. **"Member"** means a person entitled to receive Covered Services pursuant to Certificates.
- 1.7. **"ADS Services"** means those anesthesia services provided to a member of an Alternative Delivery System which are benefits under the contract between the member and such System.
- 1.8. **"Physician"** means only doctors of medicine or doctors of osteopathy for all purposes as used in this Agreement including any addenda, except Addendum A.

- 1.9. **"Qualification Standards"** means those criteria established by BCBSM which are used to determine CRNA's eligibility to become or remain a participating CRNA provider as set forth in Addendum B.
- 1.10. **"Reimbursement Policies"** means the policies by which BCBSM determines the amount of payment due CRNA for Covered Services.

ARTICLE II CRNA RIGHTS AND OBLIGATIONS

- 2.1. **Services to Members.** CRNA, within the limitations of Michigan licensure laws, will provide Covered Services to Members based on BCBSM Medical Necessity criteria as set forth in Addendum A, and as governed by this Agreement and all other BCBSM policies in effect on the dates Covered Services are provided.
- 2.2. **Qualification Standards.** CRNA will comply with the Qualification Standards established by BCBSM and agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without sixty (60) days prior written notice to CRNA. The current Qualification Standards are set forth in Addendum B.
- 2.3. **Reimbursement.** BCBSM will timely process acceptable claims submitted by CRNA and will make payment directly to CRNA for Covered Services provided only in an Approved Setting in accordance with the reimbursement methodology set forth in Addendum C. Except for copayments and deductibles, CRNA will accept the BCBSM payment as full payment for Covered Services and for any ADS Services rendered to a member of an Alternate Delivery System, and agrees not to collect any further payment, except as set forth in Addendum G.
- 2.4. **Claims Submission.** CRNA will submit acceptable claims for Covered Services and for any ADS Services provided to members of Alternative Delivery Systems directly to BCBSM using BCBSM approved claim forms, direct data entry systems, tape-to-tape systems or such other methods as BCBSM may approve from time to time. An acceptable claim is one which complies with the requirements stated in published BCBSM administrative manuals or additional published guidelines and criteria. All claims shall be submitted within one hundred eighty (180) days of the date(s) of service. Claims submitted more than one hundred eighty (180) days after the date(s) of service, shall not be entitled to reimbursement from either BCBSM or a Member except as set forth in Addendum G, or except as may be provided in the standard reimbursement policies or contractual arrangements between an Alternative Delivery System and its members.

CRNA will endeavor to file complete and accurate claims and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum F.

- 2.5. **Eligibility and Benefit Verification.** BCBSM will provide CRNA with a system and/or method to promptly verify eligibility and benefit coverages of Members; provided that any such verification by BCBSM will be given as a service and not as a guarantee of payment.

- 2.6. **Administrative Manuals and Bulletins.** BCBSM will, without charge, supply CRNA with one copy of any administrative manual, guidelines and administrative information concerning billing requirements and such other information as may be reasonably necessary for CRNA to properly provide and be reimbursed for Covered Services to Members pursuant to this Agreement.
- 2.7. **Utilization and Quality Programs.** CRNA will adhere to BCBSM's policies and procedures regarding utilization review, quality assessment, precertification and case management, or other programs established or modified by BCBSM, and will retain records as set forth in BCBSM administrative policy. BCBSM agrees to furnish CRNA with information necessary to adhere to BCBSM policies and procedures.
- 2.8. **CRNA Changes.** CRNA will immediately notify BCBSM if CRNA fails to meet any of the Qualification Standards set forth in Addendum B.
- 2.9. **Record Retention.** CRNA will prepare and maintain all appropriate medical and financial records related to Covered Services provided to Members as required by any BCBSM published policies and procedures and as required by law.
- 2.10. **BCBSM Access to Records.** BCBSM represents that BCBSM Members, by contract, have authorized CRNA to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. CRNA will release patient information and records requested by BCBSM to enable it to process claims and for pre or post-payment review of medical records and equipment, as related to claims filed.
- 2.11. **Audits and Recovery.** CRNA agrees that BCBSM may photocopy, review and audit CRNA's records to determine, but not necessarily limited to, verification of services provided, Medical Necessity of services provided, and the appropriateness of procedure codes and modifiers reported to BCBSM, and to obtain recoveries based on such audits as set forth in Addendum H.
- 2.12. **Confidentiality.** BCBSM and CRNA will maintain the confidentiality of Members' and of each party's records and information of a confidential or sensitive nature in accordance with applicable state and federal law and as set forth in Addendum D. BCBSM will indemnify and hold CRNA harmless from any claims or litigation brought by Members asserting any breach of the BCBSM Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding CRNA information and data, nor from communicating with customers, and hospitals regarding aggregated data pertaining to CRNA and his/her peer group.
- 2.13. **Appeals Process.** BCBSM will provide an appeal process for CRNA in accordance with Addendum E, should CRNA disagree with any claim adjudication or audit determination.
- 2.14. **Provider Directories.** CRNA agrees to the publication of his/her name, location and specialty to Members.
- 2.15. **Other Agreements.** BCBSM and CRNA acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

- 2.16. **Transfer of Services by BCBSM.** CRNA understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

**ARTICLE III
CRNA ACKNOWLEDGMENT OF
BCBSM SERVICE MARK LICENSEE STATUS**

This contract is between CRNA and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this contract, CRNA agrees that it made this contract based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to CRNA under this contract and no other obligations are created or implied by this language.

**ARTICLE IV
GENERAL PROVISIONS**

- 4.1. **Term.** The term of this Agreement shall begin on the later of _____, 2002 or the date BCBSM receives the duly executed Signature Document from CRNA and shall continue until terminated as provided herein below.
- 4.2. **Termination.** This Agreement may be terminated:
- a. by either party, with or without cause, upon sixty (60) days written notice to the other party,
 - b. immediately, by BCBSM, if CRNA fails to meet the Qualification Standards set forth in Addendum B.
 - c. by BCBSM for cause subject to the Departicipation Policy set forth in Addendum I, or
 - d. by BCBSM if termination of this Agreement is ordered by the State Insurance Commissioner.
- 4.3. **Existing Obligations.** Termination of this Agreement shall not affect any obligations of the Parties under this Agreement prior to the date of termination including, but not limited to, completion of all medical records and cooperation with BCBSM with respect to any actions arising out of this Agreement filed against BCBSM after the effective date of termination. This Agreement shall remain in effect for the resolution of all matters pending on the date of termination. BCBSM's obligation to reimburse CRNA for any Covered Services will be limited to those provided through the date of termination.
- 4.4. **Right of Recovery.** The expiration or termination of this Agreement or any changes as provided in this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from CRNA or based upon any audit conducted pursuant to Article II, Section 2.11.

- 4.5. **Nondiscrimination.** CRNA will not discriminate because of age, sex, race, religion, color, or national origin, in any area of CRNA's operations, including but not limited to employment, patient care, and clinical staff training and selection. .
- 4.6. **Relationship of Parties.** BCBSM and CRNA are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement.
- 4.7. **Assignment.** Any assignment of this Agreement by either party without the prior authorized written consent of the other party will be null and void, except as stated in 2.16.
- 4.8. **Amendment.** This Agreement may be altered, amended, or modified at any time, but only by the prior authorized written consent of the parties; however, BCBSM shall have the right to unilaterally amend this agreement upon giving not less than ninety (90) days prior written notice to CRNA; as provided in Section 4.12 below or, at BCBSM's discretion, by publication in the appropriate provider publication, e.g. *The Record*.
- 4.9. **Waiver.** No waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by an authorized representative of the party against whom such a waiver is being sought. Any waiver of one or more of the provisions of this Agreement or failure to enforce the Agreement by either of the parties hereto shall not be construed as a waiver of any subsequent breach of this Agreement or any of its provisions.
- 4.10. **Scope and Effect.** This Agreement shall supersede any and all prior agreements and understandings between the parties, whether written or oral, regarding the matters herein, and shall constitute the entire agreement and understanding between the parties and binding upon their respective representatives, successors and assignees.
- 4.11. **Severability.** If any provision of the Agreement is deemed or rendered invalid or unenforceable, the remaining provisions of the Agreement shall remain in full force and effect; unless any such invalidity or unenforceability has the effect of materially changing the obligations of either party.
- 4.12. **Notices.** Unless otherwise indicated, any notice required or permitted under this Agreement shall be given in writing and sent to the other party by hand-delivery, or postage pre-paid regular mail at the following address or such other address as a party may designate from time to time.

If to CRNA:

Current address shown on
BCBSM CRNA File

If to BCBSM:

Provider Registration - MC B443
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd
Detroit, Michigan 48226-2998

- 4.13. **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.

4.14. **Governing Law.** This Agreement, except as governed by federal law, will be governed and construed according to the laws of the state of Michigan.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

ADDENDA

- A. Medical Necessity Criteria
- B. Qualification Standards
- C. Reimbursement Methodology
- D. Confidentiality Policy
- E. Disputes and Appeals
- F. Service Reporting and Claims Overpayment Policy
- G. Services for Which CRNA May Bill Members
- H. Audit and Recovery Policy
- I. Departicipation Policy

ADDENDUM A
MEDICAL NECESSITY CRITERIA

Medical Necessity is determined by Physicians* acting for BCBSM. For purposes of payment by BCBSM, Medical Necessity or Medically Necessary means a determination by Physicians for BCBSM based upon criteria and guidelines developed by Physicians who are acting for their respective provider type and/or medical specialty, or, in the absence of such criteria and guidelines, based upon provider review, in accordance with accepted medical standards and practices, that the service:

is accepted as necessary and appropriate for the patient's condition and is not mainly for the convenience of the Member or Physician; and in the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.

* For purposes of this addendum only, Physician also includes Doctors of Podiatric Medicine.

**ADDENDUM B
QUALIFICATION STANDARDS**

CRNA must meet and continue to meet all of the following qualifications in order to be eligible for participation pursuant to this agreement:

- Current Michigan Licensure as a Registered Nurse (RN); with specialty certification as a Nurse Anesthetist issued by the Michigan Board of Nursing.
- Current certification from the Council on Certification of Nurse Anesthetists; or current certification from the Council on Recertification of Nurse Anesthetists.
- Absence of inappropriate utilization or practice patterns as defined by established practice protocols, that are identified through proven subscriber or professional peer complaints, peer review, and utilization management.
- Absence of fraud and illegal activities.

ADDENDUM C REIMBURSEMENT METHODOLOGY

For Covered Services, BCBSM will pay the lesser of billed charges or the fee (Fee), less copayments and deductibles. The anesthesia formula is the sum of the time reported (in 15-minute increments) plus the Anesthesia Base Units (ABUs) multiplied by the BCBSM regional conversion factor. A percentage (Percentage) based on the reported modifier is then applied to the formula. The Percentage is 40% when the service is performed under the medical direction of a Physician who is responsible for anesthesia services and who is not the operating surgeon, and 85% when the service is performed without medical direction of a Physician who is responsible for anesthesia services and who is not the operating surgeon. The resulting Fee is then compared to CRNA's charge and then copayments and/or deductibles are applied, as indicated below:

The Fee = (# time units + ABUs) x BCBSM regional conversion factor
x Percentage (i.e., 40% or 85%)

CRNA's payment = the lesser of the Fee or CRNA's charge, less copayments and deductibles.

ABUs are obtained from the Center for Medicare and Medicaid Services (CMS), however, BCBSM retains the option to modify them at its discretion.

The anesthesia formula, the BCBSM regional conversion factors, and the number of ABUs associated with each anesthesia procedure code will be published in the BCBSM Maximum Payment Schedule.

BCBSM will review the reimbursement levels periodically to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Modifications to ABUs, procedure codes, and nationally imposed changes to the nomenclature and national coding system for procedure codes which result in changes to the Fee will become effective upon notice to CRNA. All other modifications to the Fee or to BCBSM's reimbursement methodology will become effective 90 days from the date of notice by BCBSM to CRNA.

Any required notice of reimbursement changes may, at BCBSM's discretion, be published in the appropriate BCBSM publication (e.g., *The Record*).

ADDENDUM D CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of Members and the confidentiality of personal data, personal information, and CRNA financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. which requires BCBSM's Board of Directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of personal data".

In adopting this policy, BCBSM acknowledges the rights of its Members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; to know it will not be shared with others except for legitimate business purposes or in accordance with a Member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a Member, which is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a Member, including an automated or computer accessible record, containing information such as an address, age/birth date, Coordination of Benefits data, which is maintained or stored by a health care corporation.

The term "CRNA financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain CRNA financial data and information as confidential.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to Members will notify Members of these routine uses and contain the Member's consent to release data for these purposes. These forms will also advise the Members of their rights under this policy.

Upon request, a Member will be notified regarding the actual release of personal data.

BCBSM will not release Member specific personal data except on a legitimate need to know basis or where the Member has given specific authorization. Data released with the Member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the Member executes in writing another prior and specific informed

consent authorizing the additional release. Where protected by specific statutory authority, Member specific data will not be released without appropriate authorization.

Experience rated and Administrative Service Contract (ASC) customers and hospitals and other entities may obtain personal data and CRNA financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to accounts and facilities will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

ADDENDUM E
APPEALS PROCESS FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

CRNA must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW

Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, CRNA shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For **individual claims** disputes:

Blue Cross Blue Shield of Michigan
Provider Appeals Unit
Mail Code 2005
600 Lafayette East
Detroit, MI 48226-2998

For disputes regarding **professional provider utilization review audit results**:

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J 103
600 Lafayette East
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation;
- and, Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of CRNA's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If CRNA is dissatisfied with the determination of the Written Complaint/Reconsideration Review, CRNA may submit a written request for a Managerial-Level Review Conference. The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration

Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. CRNA or his/her representative will normally be in attendance to present their case. The conference can be held by telephone if CRNA prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding **individual claims** disputes:

Blue Cross Blue Shield of Michigan
Conference Coordination Unit
Mail Code 2027
600 Lafayette East
Detroit, MI 48226-2998

For Conferences regarding **professional utilization review audit results** disputes:

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
600 Lafayette East
Detroit, MI 48226-2998

A request for a Managerial-Level Review Conference must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation;
- and, Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to CRNA in writing within 30 days of the request for the Conference. The determination(s) of a Managerial-Level Review Conference delineate the following, as appropriate:

- 1) The proposed resolution;
- 2) The facts, along with supporting documentation, on which the proposed resolution was based.
- 3) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;
- 4) A statement describing the status of each claim involved in the dispute; and
- 5) If the determination is not in concurrence with the Professional appeal, a statement explaining CRNA's right to appeal the matter to the Michigan Office of Financial and Insurance Services within 120 days after receipt of BCBSM's written response to the Conference, as well as CRNA's option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving **issues of Medical Necessity** that are resultant from medical record reviews, CRNA may submit a written request for an External Peer Review if he/she are dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, CRNA can request a review by an external peer review organization to review the medical record(s) in dispute. CRNA will normally be notified of the determination(s) made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon CRNA and BCBSM.

If BCBSM's findings are upheld on appeal, CRNA will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of CRNA's right to appeal any Medical Necessity issues to the Michigan Office of Financial and Insurance Services or to initiate an action on those issues in a state court.

The CRNA request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
600 Lafayette East
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Blue Cross Blue Shield of Michigan
Conference Coordination Unit
Mail Code 2027
600 Lafayette East
Detroit, MI 48226-2998

INTERNAL REVIEW COMMITTEE

For disputes involving **Administrative and/or Billing & Coding issues**, CRNA may submit a written request for a review by the BCBSM Internal Review Committee (IRC) which is composed of 3 members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy(ies) in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM's response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. CRNA, or his/her representative and upon CRNA's written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Director, Utilization Management MC J 423
Blue Cross Blue Shield of Michigan
600 Lafayette East
Detroit, MI 48226-2998

If CRNA is dissatisfied with the determination of the Internal Review Committee, he/she may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's board of directors) or directly to the Michigan Office of Financial and Insurance Services; or initiate an action in an appropriate state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, CRNA may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee (PRC); a sub-committee of the BCBSM Board of Directors composed of BCBSM participating professionals, community leaders, and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. CRNA must represent themselves at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

Director, Utilization Management MC J423
Blue Cross Blue Shield of Michigan
600 Lafayette East
Detroit, MI 48226-2998

If CRNA is dissatisfied with the determination of the Provider Relations Committee, he/she may appeal the determination to the Michigan Office of Financial and Insurance Services, or initiate an action in an appropriate state court.

MICHIGAN OFFICE OF FINANCIAL AND INSURANCE SERVICES

Informal Review & Determination

If CRNA is dissatisfied with BCBSM's response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if CRNA believes that BCBSM has violated a provision of either Section 402 or 403 of P.A. 350, CRNA shall have the right to submit a request to the Michigan Office of Financial and Insurance Services for an Informal Review & Determination (IR&D).

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of P.A. 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Michigan Office of Financial and Insurance Services
Post Office Box 30200
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Office of Financial and Insurance Services. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Office of Financial and Insurance Services shall issue its determination.

Contested Case Hearing

If dissatisfied with the Office of Financial and Insurance Services' determination, either CRNA or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Office of Financial and Insurance Services' Determination is mailed, and shall be mailed to the Office of Financial and Insurance Services at the same address found in the prior step.

CIVIL COURT REVIEW

Either CRNA or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

STATE COURT SYSTEM

Also, as noted above, at any time after the completion of the Written Complaint or Reconsideration Review and Management Review Conference steps, CRNA may attempt to resolve the dispute by initiating an action in the appropriate state court.

ADDENDUM F
SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

CRNA will furnish a report to BCBSM in the form BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge, with complete and accurate information, including diagnosis with procedure codes approved by BCBSM, license number of reporting CRNA and such other information as may be required by BCBSM to adjudicate claims.

CRNA will use a provider identification code acceptable to BCBSM for billing of covered services.

CRNA agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for covered services by requesting information from Members, including but not limited to information pertaining to worker's compensation, other group health insurance, third party liability and other coverages. CRNA further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When CRNA is aware the patient has primary coverage with another third party payer or entity, CRNA agrees to submit the claim to that party before submitting a claim for the services to BCBSM. BCBSM's secondary coverage will be limited to the difference, if any, between the maximum amount BCBSM would have otherwise paid less the amount paid by the primary carrier. If the primary carrier's payment exceeds the BCBSM maximum payment, no secondary coverage will be provided by BCBSM.

II. Overpayments

CRNA shall promptly report overpayments to BCBSM discovered by CRNA, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by CRNA or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where CRNA appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the last unappealed determination. If audit refund recoveries and other overpayment obligations are not fully repaid over the course of one month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.

ADDENDUM G
SERVICES FOR WHICH CRNA MAY BILL MEMBER

CRNA may bill Member for:

1. Non-Covered Services unless the service has been deemed a non-Covered Service solely as a result of a determination by a Physician acting for BCBSM that the service was Medically Unnecessary, or experimental or investigational, in which case CRNA assumes full financial responsibility for the denied claims. CRNA may bill the Member for claims denied as Medically Unnecessary, or experimental or investigational, only as stated in paragraph 2, below;
2. Services determined by BCBSM to be Medically Unnecessary, or experimental or investigational, where the Member acknowledges that BCBSM will not make payment for such services, and the Member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;
3. Covered Services denied by BCBSM as untimely billed, if all of the following requirements are met:
 - a. CRNA documents that a claim was not submitted to BCBSM within one hundred eighty (180) days of performance of such services because a member failed to provide proper identifying information; and
 - b. CRNA submits a claim to BCBSM for consideration for payment within three (3) months after obtaining the necessary information.

ADDENDUM H AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Blue Cross or Blue Shield Plan Members' medical records or other pertinent records of CRNA to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse CRNA for the reasonable copying expense incurred by CRNA where CRNA copies records requested by BCBSM in connection with BCBSM audit activities.

CRNA shall prepare and maintain all appropriate records on all Members receiving services, and shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to CRNA by BCBSM, and such requirements subsequently developed which are communicated to CRNA prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, Medical Necessity of services provided, and appropriateness of procedure codes and modifiers reported to BCBSM for the services rendered.

III. Time

BCBSM may conduct on-site audits during CRNA's regular business hours. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not Medically Necessary as determined by BCBSM under Addendum A. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two (2) years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

ADDENDUM I DEPARTICIPATION POLICY

BCBSM policy establishes the mechanism, criteria and responsibility for departing facility and professional providers under Regular Business. Departicipated providers will have claims subjected to Prepayment Utilization Review and processed as nonparticipating with payments directed to the Members. This policy provides for review and recommendation by the Audits and Investigations Subcommittee (AIS).

All BCBSM provider types and subspecialties within those provider categories are covered under this policy.

Criteria under which a provider may be recommended for departing include, but are not limited to, providers who are determined to be involved in the inappropriate use or billing of services, providers who are convicted of fraudulent or criminal acts involving BCBSM, Medicare, Medicaid, or other third party carriers; providers who have had their licensure/certification/accreditation suspended or revoked in Michigan; providers who refuse access to records for audit purposes; and providers who are in violation of local, state or federal regulations, laws, codes, etc. (See DEPARTICIPATION CRITERIA.)

Appeal requests must be submitted in writing by an executive representative of the facility, the provider and/or his/her duly authorized representative.

The AIS will review the recommendation and make a determination regarding departing of the provider. The departing is effective upon notice to the provider. The AIS will receive any subsequent appeal.

The Opinion Review Board (ORB) will hear all provider related departing appeals. The ORB determination may be appealed to the Provider Relations Committee (PRC) of the BCBSM Board of Directors.

The PRC hears appeals based only on the facts and findings of previous reviews. The PRC decision is the final level of the appellate process.

DEPARTICIPATION CRITERIA

Criteria under which a provider may be recommended for deparicipation include, but are not limited to, the following:

1. Any felony conviction or misdemeanor involving BCBSM, Medicare, Medicaid, and/or other health care insurers.
2. Termination or suspension of licensure, certification, registration, certificate of need, or accreditation in Michigan.
3. Providers who continue to be noncompliant in their reporting after documented notification.
4. Providers who, after notification, continue to bill patients for amounts in excess of deductibles and co-payments.
5. Providers who, upon audit, fail to document the necessity of 50% or more of the audited services billed to BCBSM.
6. Providers identified as prescribing/dispensing controlled substances for other than therapeutic reasons.
7. Providers demonstrating a pattern of billing for services not rendered or not medically necessary.
8. Providers refusing access to records which are deemed essential for BCBSM to determine its liability.
9. Providers found to be inducing patients to receive services through the use of work slips, prescriptions, or money.
10. Providers advertising free service, then billing BCBSM additional services which are not medically indicated.
11. Providers who have identified refunds in excess of \$100,000.00.
12. Providers who are in violation of local, state or federal regulations, laws, codes, etc.



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Nurse Specialists Provider Class Plan Detailed Report 2006-2007

EXECUTIVE SUMMARY

Goal Achievement

BCBSM met the access and quality of care goals during the reporting period. Although the cost goal for the nurse specialists provider class was not independently met, there is competent, material and substantial information to support a determination that the failure to achieve the goal was reasonable in accordance with Section 510(1)(b) of PA 350.

Cost Performance

The 4.6 percent cost goal for the nurse specialists provider class was not met. An increase of 7.8 percent in the payment trend was due to a 6.2 percent increase in use of services and a 1.0 percent increase in payment per service. A number of factors impacted the trend:

- ◆ Payments to certified nurse anesthetists accounted for more than 78 percent of the increase.
- ◆ The top diagnoses ranked by payments were musculoskeletal disorders, digestive system disorders, neoplasms and genitourinary disorders. These diagnoses accounted for 48 percent of payments to nurse specialists in 2007.
- ◆ Payment trend growth exceeded the cost goal in most regions of the state. Regions one, three and nine experienced double-digit increases.
- ◆ Members aged 55-64 had the highest use rates and accounted for the highest proportion of utilizing members.
- ◆ The growing prevalence of chronic health conditions is driving the increased demand for health care services.

Access Performance

There was an appropriate number of participating nurse specialists providers throughout the state to ensure the availability of covered health care services to each BCBSM member. BCBSM maintained a formal participation rate of nearly 94 percent for all nurse types and an average per-claim participation rate of nearly 99 percent for certified nurse midwives and certified registered nurse anesthetists. The major factors affecting access performance during this reporting period included:

- ◆ Effective communications with nurse specialists including BCBSM's publications, on-line assistant tools, provider outreach fairs and provider consultants helped maintain a strong working relationship with nurse specialists.
- ◆ BCBSM's reimbursement methodology, which is outlined in the provider manual and participation agreement, provided nurse specialists with equitable income to provide services to BCBSM's members.

Quality of Care Performance

BCBSM ensured that nurse specialists met and abided by reasonable standards of health care quality. Major factors affecting quality of care performance during this reporting period included:

- ◆ Enforcing licensure requirements and qualification standards through a provider credentialing process to ensure quality care to members.
- ◆ Supporting quality management initiatives, including programs promoting safety, improving community health, encouraging wellness and ensuring delivery of high quality health care.
- ◆ Maintaining effective provider relations through liaison committee meetings, regular continuing nurse and medical education seminars and a formal appeals process to ensure quality communication with nurse specialists.

PLAN OVERVIEW

Providers

Certified nurse midwives (CNM), certified nurse practitioners (CNP) and certified registered nurse anesthetists (CRNA)

Qualifications

Licensed by the state of Michigan as a registered nurse with specialty certification from the Michigan Board of Nursing and certification from a national nursing organization

Participation Status

Formal basis, with per-claim participation applicable to CNMs and CRNAs

Covered Services

CNMs are limited to basic ante partum care, normal vaginal deliveries and postpartum care. CNMs are reimbursed for deliveries only when the delivery occurs in the inpatient hospital setting, or in a hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital.

CNPs are reimbursed for a broad range of services including complete physicals, health assessments, treatment of common acute illnesses and chronic stable medical conditions, and psychiatric services.

CRNAs are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities.

Reimbursement

BCBSM reimburses participating nurse specialists for covered services deemed medically necessary by BCBSM. Addendum A of each of the attached participation agreements describes the determination of medical necessity.

Covered Services

Nurse specialists are reimbursed for a variety of services where BCBSM considers them qualified and licensed to perform in accordance with benefits covered by member certificates.

Reimbursement Methods

The following definition applies to the reimbursement methods for all nurse specialists:

Billed Charge

The billed charge refers to the actual charge indicated on the claim form submitted by the provider.

The following definition applies to the reimbursement methods for CNMs and CNPs:

Maximum Payment Level

Most of the Maximum Payment Schedule is based on the Resource Based Relative Value System developed by the Centers for Medicare and Medicaid Services, in which services are ranked according to the resource costs needed to provide them.

The resource costs of the RBRVS system include physician time, training, skill, risk, procedure complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Other factors that may be used in setting maximum payment levels include comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM will give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level. BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

BCBSM reviews relative values and reimbursement levels periodically and may adjust them as necessary.

An alternative reimbursement arrangement is available to groups through the Medical Surgical 90 program. The MS-90 program increases reimbursement levels for purposes of reducing out-of-pocket payments in regions where participation rates are low.

Certified Nurse Midwives

For each covered service performed, BCBSM will pay the lesser of the billed charge or the maximum payment level for allowable procedures. Allowable procedures for CNMs are limited to basic antepartum care, normal vaginal deliveries and postpartum care.

CNMs are reimbursed for deliveries only when the delivery occurs in the inpatient hospital setting, or in a hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital.

Certified Nurse Practitioners

For each covered service performed, BCBSM will pay the lesser of the billed charge or 85 percent of the maximum payment level.

Certified Registered Nurse Anesthetists

Certified registered nurse anesthetists are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities. Services are only approved when personally performed within the CRNA's scope of practice.

BCBSM will pay the lesser of the billed charge or a fee based on an anesthesia formula less copays and deductibles. The fee is calculated by multiplying a regional conversion factor by the sum of time (in 15-minute units) plus anesthesia base units, which is then multiplied by a percentage factor. The percentage is 40 percent when the service is performed under the medical direction of a physician responsible for anesthesia services, who is not the operating surgeon, and 85 percent when the service is performed without medical direction of a physician who is responsible for anesthesia services and who is not the operating surgeon. The calculation may be stated as:

Fee = [(# time units + ABUs) x BCBSM regional conversion factor] x percentage (that is, 40 percent or 85 percent)

ABUs are obtained from the Centers for Medicare & Medicaid Services; however, BCBSM retains the option to modify them at its discretion. The conversion factors used to derive the fees will be based on geographic area, with the goal of equalizing payment levels by geographic area over time.

Retroactive Payments

After a CRNA obtains Nurse Anesthetist Specialty Certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA initially received national certification from the Council on Certification of Nurse Anesthetists. Retroactive reimbursement is available only to CRNAs upon their initial certification. Covered services rendered after national certification has been obtained will be reimbursed if the

requirements of the members' benefit plan and the CRNA's contract with BCBSM have been met.

Benefit Issues

Benefits for nurse specialist services are included in underwritten certificates and may be optional for self-funded groups.

Plan Updates

The plan was updated in October 2006 to:

- ◆ Allow reimbursement to CNPs for services provided in an inpatient setting
- ◆ Revise qualification standards for CNMs
- ◆ Allow CNMs to have a written arrangement with a consultant physician for emergency and hospital admissions instead of their own admitting privileges

EXTERNAL INFLUENCES

Market Share

Table 1 illustrates BCBSM’s commercial (private) market share for members with nurse specialists’ benefits. As shown, BCBSM’s share of the commercial market in Michigan increased slightly in each region between 2007 and 2006. Total market share in Michigan increased from 32.3 percent in 2006 to 34.6 percent in 2007. The increase in BCBSM market share is the result of a decrease in Michigan population, and the addition of certified nurse practitioner benefits as a payable service for some major self-funded customer groups.

Table 1
Nurse Specialist Providers
BCBSM Share of Michigan Market

Region	2007			2006		
	Michigan Population*	BCBSM Nurse Specialists Members**	Market Share	Michigan Population*	BCBSM Nurse Specialists Members**	Market Share
1	3,046,972	1,001,780	32.9%	3,185,649	988,880	31.0%
2	512,279	135,156	26.4%	524,273	131,367	25.1%
3	421,019	172,536	41.0%	452,036	175,641	38.9%
4	365,387	158,621	43.4%	376,840	149,734	39.7%
5	743,061	234,758	31.6%	791,283	228,538	28.9%
6	991,910	270,749	27.3%	1,048,234	269,170	25.7%
7	438,479	215,201	49.1%	473,316	208,920	44.1%
8	310,708	151,343	48.7%	341,938	152,903	44.7%
9	163,721	78,660	48.0%	181,436	78,598	43.3%
Statewide	6,993,536	2,418,804	34.6%	7,375,005	2,383,751	32.3%

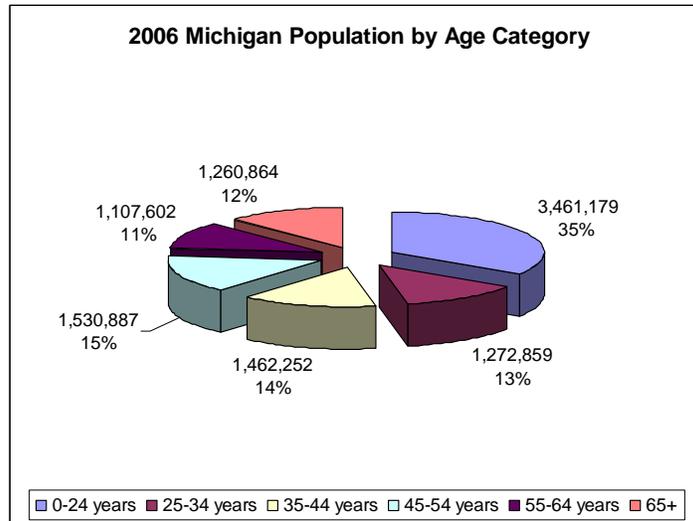
* Excludes Medicare and Medicaid recipients

** Membership is an average of CNP, CRNA and CNM

Demographics

The characteristics of a population may significantly affect that population’s consumption of health care resources. The aging population also has a high correlation to health care use rates. Michigan residents aged 45-64 years comprised 26.1 percent of the state’s overall population compared to 25.0 percent for the same age group in the United States. Michigan’s median age of 37.2 is slightly higher than the national median age of 36.4. Chart 1 provides a distribution of Michigan’s population in 2006 by age group.

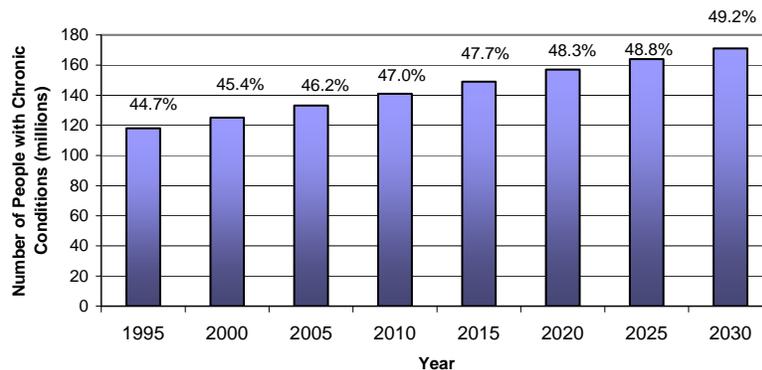
Chart 1



Epidemiological Factors

While today's rates of chronic conditions are high, the proportion of the population affected by one or more chronic diseases is expected to grow. By 2025, chronic diseases will affect an estimated 164 million Americans – nearly half (49 percent) of the population.¹ Chart 2 illustrates rates of chronic conditions in the U.S. projected through 2030, when an estimated 49 percent of the population is expected to have one or more chronic conditions based on current trends.¹

Chart 2
Increase in Chronic Conditions
1995, 2000 and 2005 Actual Rates Projected Through 2030¹



¹ “Chronic Conditions: Making the Case for Ongoing Care,” Partnership for Solutions, September 2004 Update, available at: <http://www.rwjf.org/files/research/chronicbook2002.pdf>.

Michigan outranks most states in the percent of the adult population with chronic conditions such as:

- ◆ Obesity – Michigan ranked 9th in the nation, with an obesity rate of 27 percent compared to the national rate of 24 percent (2004-2006 average). An additional 36 percent of Michiganders are considered overweight, while only 35 percent are neither overweight nor obese. Obesity is a major risk factor for a number of chronic conditions including diabetes, hypertension, cardiovascular disease and cancer.²
- ◆ Diabetes – Michigan ranked 11th in the nation, with an adult diabetes rate of 8.3 percent compared to the national rate of 7.4 percent (2004-2006 average).²
- ◆ Hypertension – Michigan ranked 13th in the nation, with 27 percent of the population diagnosed with hypertension compared to the national rate of 25 percent (2001-2005 average).²
- ◆ Cancer- Michigan ranked 8th in the nation in the number of new cases of cancer in 2006.²

Michigan also fares poorly with respect to the prevalence of lifestyle factors that contribute to chronic health conditions, such as smoking, lack of exercise, and diet.² Chronic diseases, such as heart disease, stroke, cancer, and diabetes are among the most prevalent, costly, and preventable of all health problems.¹

Nurse specialists increase access to affordable, quality primary health care and provide a less expensive alternative to physician services. Demand for the services of nurse specialists is expected to grow as a result of greater demand for medical care to treat and manage chronic conditions and an aging population.

Nurse practitioners provide a wide range of preventive and acute health care services to individuals of all ages. Nurse practitioners take health histories and provide complete physical examinations; diagnose and treat many common acute and chronic problems; interpret laboratory results and X-rays; prescribe and manage medications and other therapies. They also provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance; and refer patients to other health professionals as needed.³ Approximately 60 to 80 percent of primary and preventive care can be performed by nurse practitioners, relieving primary care physicians to perform more acute care services.³

Each year, more than 26 million people in the United States undergo medical procedures requiring anesthesia. In many of these cases, the anesthesia is administered by a certified registered nurse anesthetist (CRNA). There are more than 36,000 nurse anesthetists in the U.S. and demand continues to outpace the supply.⁴

²“ The State of Your Health: Michigan”, <http://healthyamericans.org>., data through 2006.

³ <http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465>.

⁴ <http://www.nursinglink.com/careers/3802-certified-registered-nurse-anesthetist-careers>.

The number of deliveries performed by nurse midwives is expected to grow nationally. According to the most recent data available, CNMs in Michigan attended almost 8,000 births or approximately 6.1 percent of total births during the year. Nurse-midwives also provide prenatal and postnatal care to women, family planning and birth control counseling.

Economic Factors

National Health Expenditures

National health expenditures rose 6.8 percent in 2006 and 6.7 percent in 2007.⁵ Total 2007 health expenditures were projected to be almost \$2.3 trillion, which translates to \$7,439 per person, compared to actual per capita spending of \$7,026 in 2006.⁶

As a percentage of Gross Domestic Product (GDP), health care spending is projected to increase to 16.3 percent in 2007 from 16.0 percent in 2006. The healthcare spending share of GDP remained relatively stable in 2006 and 2007 as a result of relatively slower healthcare spending growth (since a recent peak of 9.1 percent in 2002), coupled with strong overall national economic growth during most of 2007.⁶

Nurse specialists are included in the physician and clinical services component of health care spending. This component grew 5.9 percent in 2006 and 5.7 percent in 2007, the slowest rates of growth since 1999. This slowdown was driven by lower price growth, fueled by a near freeze on Medicare physician payments (the fee schedule update was 0.2 percent in 2006), which influenced private payers as well.⁶ BCBSM professional medical surgical fees increased 1.0 percent on January 1, 2006, followed by an additional increase of 2.5 percent on July 1, 2006, and 2.5 percent as of July 1, 2007.

Inflationary Factors

As mentioned in the epidemiology section, the impact of chronic disease on health care costs cannot be ignored. Diagnoses related to obesity, diabetes and cardiovascular disease have consistently affected health care costs. The growth in chronic conditions and an aging population are increasing utilization of health services. At the same time, technological advances continue to provide new treatment options, which drive up the cost of care. For example, advanced techniques and technologies have revolutionized hip replacements, allowing more arthritis patients to consider treatments and at an earlier stage than they had in the past,⁷ resulting in increased demand for anesthesia services from CRNAs.

⁵ <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2006.pdf>.

⁶ <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>.

⁷ <http://www.hipreplacement.com/DePuy/treatment/index.html>.

COST GOAL PERFORMANCE

“Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.” This is expressed by the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

PA 350 Cost Objectives

Objective 1

Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.

Objective 2

Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement.

Performance - Cost Goal and Objectives

BCBSM’s two-year average increase in payments per 1000 members was 7.8 percent for the nurse specialists provider class. This increase exceeds the PA 350 cost goal of 4.6 percent. Although the nurse specialists provider class did not independently achieve the cost goal, there is competent, material and substantial information to support a determination that the failure to achieve the goal was reasonable in accordance with Section 510(1)(b) of PA 350. Table 2 illustrates the cost performance for the nurse specialists provider class during the reporting period of 2005-2007.

**Table 2
Nurse Specialists Provider Class 2005-2007 Performance Against Cost Goal**

	2007	2006	2005
Certified Nurse Midwives			
Payments for CNMs			
Total	\$615,861	\$628,938	\$710,203
Per 1,000 members	\$248.66	\$253.67	\$274.58
% change	-2.0%	-7.6%	
Services for CNMs			
Total	2,507	2,482	2,831
Per 1,000 members	1.01	1.00	1.09
% change	1.1%	-8.5%	
Payment/Service (CNMs)	\$245.66	\$253.40	\$250.87
% change	-3.1%	1.0%	
Certified Nurse Practitioners			
Payments for CNPs			
Total	\$6,091,282	\$4,838,342	\$4,186,703
Per 1,000 members	\$2,659.24	\$2,172.12	\$1,901.61
% change	22.4%	14.2%	
Services for CNPs			
Total	118,694	103,681	96,578
Per 1,000 members	51.82	46.55	43.87
% change	11.3%	6.1%	
Payment/Service (CNPs)	\$51.32	\$46.67	\$43.35
% change	10.0%	7.6%	
Certified Registered Nurse Anesthetists			
Payments for CRNAs			
Total	\$46,338,583	\$44,222,541	\$40,895,100
Per 1,000 members	\$18,616.82	\$18,091.46	\$16,367.34
% change	2.9%	10.5%	
Services for CRNAs			
Total	248,876	240,138	226,371
Per 1,000 members	99.99	98.24	90.60
% change	1.8%	8.4%	
Payment/Service (CRNAs)	\$186.19	\$184.15	\$180.66
% change	1.1%	1.9%	
Members for CNMs	2,476,734	2,479,394	2,586,467
Members for CNPs	2,290,608	2,227,471	2,201,667
Members for CRNAs	2,489,070	2,444,387	2,498,579
Payments for Certified Nurse Specialists			
Total	\$53,045,725	\$49,689,820	\$45,792,006
Per 1,000 members	\$21,524.72	\$20,517.25	\$18,543.53
% change	4.9%	10.6%	
Achievement of Cost Goal			
Two Year Avg. Percent Change:	7.8%	2007 percent of Total Payout reported to OFIR*	
P.A. 350 Cost Goal	4.6%	1.6%	
Goal Not Met		2007 ASC Business	
		55.9%	

*Payout reported to OFIR includes Traditional claims for the hospital, MD, DO, clinical laboratory, fully licensed psychologist, ESRD, podiatrist and chiropractor provider classes. Traditional and PPO claims are included for the outpatient psychiatric care and substance abuse provider classes. Traditional, PPO and POS claims are included for the SNF, home health care, ASF, hospice, DME/P&O, ambulance, nurse specialists, rehabilitation therapy, HIT, dental, vision, hearing and pharmacy provider classes. See the technical notes section for more details.

The two-year average increase in payments per 1000 of 7.8 percent resulted from annual increases in payments per 1000 members of 4.9 percent in 2007 and 10.6 percent in 2006. While payment and use trends increased for the nurse specialty provider class, trends by individual nurse specialty and their impacts varied significantly.

The cost section of this report provides an analysis of the factors influencing the nurse specialist provider class cost and use trends. The analysis examines the impacts by nurse specialty, types of service categories, location of service, regional variations, and age. Additional supporting data are found in Appendix C.

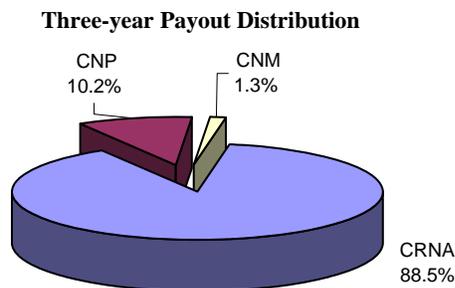
Cost , Use and Price

As illustrated in Tables 2 and 3, the three-year payout for the nurse specialists provider class totaled \$148.5 million and accounted for 1.6 percent of total BCBSM payments during the reporting period. During this time, the average number of members with nurse specialists benefits remained stable. Payments per 1000 increased 7.8 percent as a result of a 6.2 percent increase in use of services and a 1.0 percent increase in payment per service.

Table 3
Nurse Specialists Provider Class
2005 - 2007

Provider Class	Two-year Average Rate of Change			Three-year Payout	Contribution to Trend*	Percent Contribution to Trend
	Payments Per 1000 Members	Services Per 1000 Members	Payment Per Service			
CNM	-4.8%	-3.7%	-1.0%	\$ 1,955,001	-0.1%	-1.0%
CNP	18.3%	8.7%	8.8%	\$ 15,116,326	1.7%	22.0%
CRNA	6.7%	5.1%	1.5%	\$ 131,456,224	6.0%	78.9%
Total	7.8%	6.2%	1.0%	\$ 148,527,552	7.6%	100.0%

* Contribution to trend is the two-year average rate of change in payments per 1000 weighted by the ratio of 2005 payments for that nurse specialist to 2005 total nurse specialists payments.



Growth in the use of services was the major driver of the higher payment trend and is the reason BCBSM did not achieve the cost goal for the nurse specialists provider class.

As illustrated in Table 3, payment and use trends varied significantly by nurse specialty. CNPs led the two year average cost trend with an 18.3 percent increase in payments per 1000 members. The higher CNP trend was a result of an 8.7 percent increase in use and an 8.8 percent increase in payment per service.

The CRNA payment trend increased at an average annual rate of 6.7 percent primarily as a result of higher use, which increased an average of 5.1 percent during the reporting period. Payment per service increased 1.5 percent. CNM payments per 1000 members declined 4.8 percent as a result of a 3.7 percent drop in use and a 1.0 percent drop in payment per service.

Because CRNAs received 88.5 percent of payments to nurse specialists, they were the major driver of growth in the payment trend. CRNAs accounted for 79 percent of the payment trend, while CNPs accounted for 22 percent of the increase. CNMs received 1.3 percent of total payments and had a negligible impact on the payment trend.

Table 4 illustrates how the mix of services contributed to higher payment trends. Anesthesia services were responsible for 76 percent of the growth in payments per 1000. Medical visits and other medical services combined accounted for almost 20 percent of the increase in payments. As illustrated in Table 4, other types of services performed by nurse specialists had minimal impact on the average payment trend.

Table 4
Nurse Specialists Provider Class
2005 – 2007 Trends

Type of Service	2005 - 2007				Two Year Average Rate of Change		
	Payments	Services	% of Payments	% of Services	Pmt/1000	Serv/1000	% Cont. to Trend
Anesthesia	\$131,281,580	713,214	88.4%	68.4%	6.7%	5.0%	76.3%
Medical Visit	\$9,188,509	174,853	6.2%	16.8%	14.4%	9.1%	12.1%
Med Services	\$3,280,322	67,396	2.2%	6.5%	30.9%	15.9%	7.7%
Surgery	\$1,237,213	25,944	0.8%	2.5%	20.8%	6.3%	2.0%
Psych/Sub Abuse	\$784,253	14,304	0.5%	1.4%	12.9%	11.4%	0.9%
Consultation	\$334,279	2,602	0.2%	0.2%	56.8%	45.4%	1.3%
Prof Component	\$482,379	37,250	0.3%	3.6%	-15.0%	-6.5%	-0.9%
Maternity	\$1,768,997	3,607	1.2%	0.3%	-2.7%	4.4%	-0.5%
Other	\$170,019	2,988	0.1%	0.3%	50.6%	21.4%	1.1%
TOTAL	\$148,527,552	1,042,158	100.0%	100.0%	7.8%	6.2%	100.0%

BCBSM nurse specialists cost and use trends mirror national trends with respect to the growth of surgical and diagnostic procedures requiring anesthesia. Certified registered nurse anesthetists (CRNAs) administer approximately 65% of the anesthetics given to patients in the United States.⁸ They practice in a variety of settings, including hospital surgical suites, delivery rooms and ambulatory surgical centers. By providing an alternative to physician services, CRNAs increase access to anesthesiology services at reduced cost.

⁸ The Nurse Anesthesia Profession, Medical Center of Central Georgia, 2008.

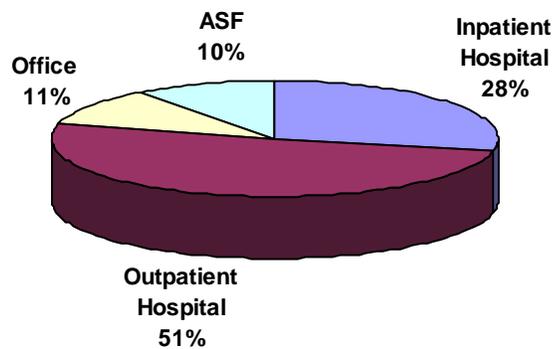
The top diagnostic categories by payments for CRNAs were musculoskeletal disorders, digestive system disorders, neoplasms and genitourinary system disorders. These were also the top diagnostic categories for all nurse specialists. The top diagnostic categories accounted for 56 percent of payments to CRNAs and 48 percent of payments to all nurse specialists in 2007. The top procedures for CRNAs in 2007 were intestinal endoscopic procedures, upper GI endoscopy, procedures of the knee joint, lower leg/ankle/foot, shoulder joint and anesthesia for labor and Cesarean delivery.

Demand for anesthesia services is expected to continue to grow as the number of surgical procedures climbs. New technology, an aging population and higher rates of obesity are fueling ever growing surgery rates for musculoskeletal disorders, cancer and circulatory diseases. A study in the April 2007 Journal of Bone & Joint Surgery predicted that demand for primary hip replacement would grow 174 percent by 2030 and for an initial knee replacement by 673 percent.⁹

Location of Service

Chart 3 illustrates the distribution of 2007 payments to nurse specialists by location of service. Fifty-one percent of payments to nurse specialists were for services provided in the hospital outpatient setting, while 28 percent of payments were for services provided in the hospital inpatient location. Eleven percent of payments were for office-based services and 10 percent for services rendered in an ambulatory surgical facility (ASF).

Chart 3
Nurse Specialist Payments by Location of Service
2007



⁹ “Hip, Knee Replacement Surgery Rates Skyrocket Over 7 Years”, Amednews.com, May 5, 2008 at [ama-assn-org/amednews/2008/05/05/hlsb0505.htm](http://ama-assn.org/amednews/2008/05/05/hlsb0505.htm).

Payments per 1000 increased in all locations except the hospital inpatient setting, where they declined an average of 3.0 percent. ASF payments per 1000 increased at an average rate of 39.4 percent. Hospital outpatient and office payments per 1000 grew an average of 10.0 percent and 10.9 percent, respectively. Hospital outpatient payments per 1000 had the largest impact on the average payment trend since the majority of services were performed in the hospital outpatient setting.

Chart 4
Nurse Specialists Provider Class
Annual Percent of Payments per 1000 by Location of Service
2005-2007

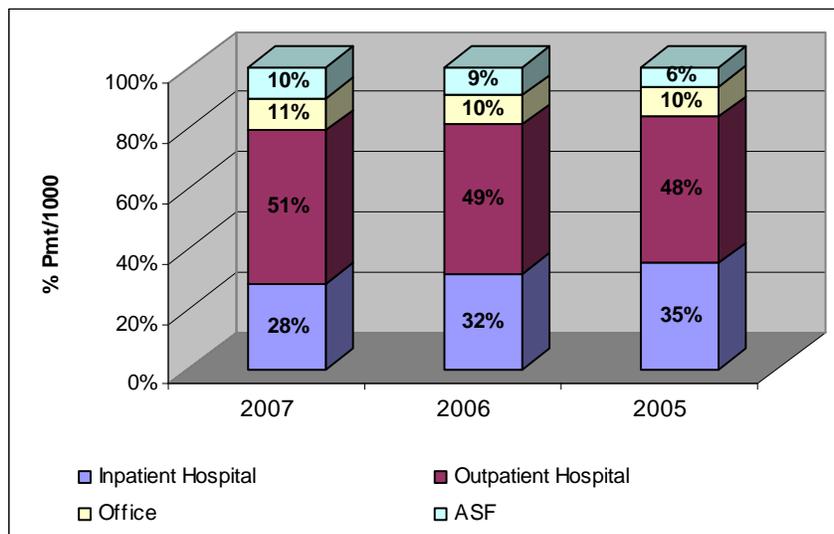


Table 5
Nurse Specialists Provider Class
Payments and Services per 1000 by Year
2005-2007

Location of Service	2 Year Avg Rate of Change		Contribution to Trend	
	Payments/1000	Services/1000	Payment Trend	Use Trend
Inpatient Hospital	-3.0%	-3.8%	-13.6%	-10.8%
Outpatient Hospital	10.0%	5.5%	62.9%	40.2%
Office	10.9%	3.8%	12.7%	18.8%
ASF	39.4%	44.2%	32.5%	45.8%
Other	14.2%	10.6%	0.3%	0.7%
Total	7.8%	6.2%	100.0%	100.0%

The growth in the nurse specialists payment trend was primarily due to increased use of services. Use grew in all locations except the hospital inpatient setting, where it declined 3.8 percent.

ASF use surged at an average rate of 44.2 percent during the reporting period, while hospital outpatient use increased an average of 5.5 percent. Higher use in the ASF and hospital outpatient

locations accounted for 86 percent of the growth in the use trend for nurse specialists. During this time hospital inpatient use declined 3.8 percent and office use increased 3.8 percent.

The use of ambulatory surgery as an alternative to inpatient surgery has become more common, and outpatient surgeries account for a growing proportion of surgeries. Of the 50 million surgeries performed annually, about 54 percent are performed in the hospital outpatient setting while 31 percent occur at free-standing ambulatory surgical centers (ASF).¹⁰

Utilization by Region

Region one accounted for 57.2 percent of payments to nurse specialists. Average payment rates per 1000 members increased by double-digits in regions one, three and nine. Region seven, which had an average payment trend of -6.2 percent, was the only region to experience a decline in the average payment per 1000.

Use rates increased in all regions except regions two, five and seven. Use declined between 1.7 percent and 4.5 percent in these regions despite growth in access. A map of the regions by county is located in Appendix D.

Table 6
Nurse Specialist Provider Class Trends by Region
2005 – 2007

Region	Two-year Average Rate of Change			Three-year Payout	% of Total Payout
	Payments Per 1000	Services Per 1000	Payment Per Service		
01	11.3%	10.3%	0.7%	\$84,984,317	57.2%
02	2.4%	-4.5%	7.2%	\$2,536,798	1.7%
03	13.1%	16.3%	-2.5%	\$6,743,642	4.5%
04	8.7%	6.6%	2.3%	\$8,852,572	6.0%
05	4.7%	-1.7%	5.9%	\$11,035,438	7.4%
06	6.5%	3.0%	3.2%	\$13,408,494	9.0%
07	-6.2%	-1.8%	-5.1%	\$10,561,127	7.1%
08	1.5%	7.8%	-6.2%	\$7,273,349	4.9%
09	12.1%	10.1%	1.7%	\$3,131,815	2.1%
Statewide	7.8%	6.2%	1.0%	\$148,527,551	100.0%

¹⁰ Marcus, Mary Brody. "The Spotlight Grows on Outpatient Surgery", *USA Today*. July 29, 2007.

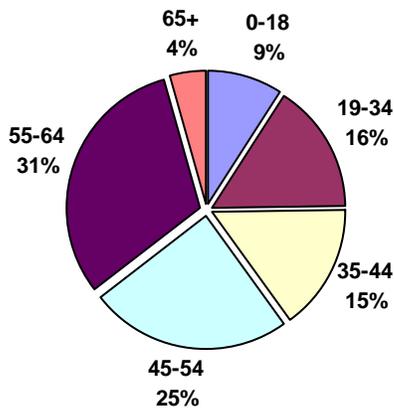
Utilization by Age

In 2007, 9.7 percent of members eligible for nurse specialists benefits obtained services from these providers. Members aged 55-64 had the highest use rates. These members represented 14.2 percent of the membership yet they accounted for 28.3 percent of patients. Members aged 45-54 had the second highest proportion of utilizing members. These findings are consistent with national trends showing that people tend to use more health care as they age. Health care spending is expected to grow to reflect generally higher per capita spending as the population ages. Nurse specialists membership counts by age category can be found in Appendix C10.

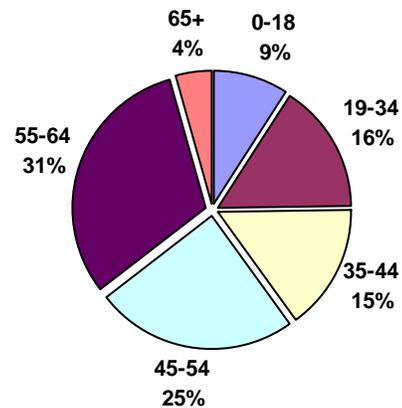
Table 7
Nurse Specialists Provider Class
2007 Patient Count and Payments by Age Category

Age Category	Membership % by Age	Patient Count by Age	Patients as a % of Members	% Distribution Patients	2007 Payments	Payment Percent
0-18	29.2%	30,965	4.1%	12.4%	\$4,821,490	9.1%
19-34	19.5%	39,506	7.9%	15.8%	\$8,304,060	15.7%
35-44	16.7%	38,614	9.0%	15.5%	\$8,037,864	15.2%
45-54	19.0%	60,548	12.4%	24.3%	\$13,020,486	24.5%
55-64	14.2%	70,605	19.3%	28.3%	\$16,520,798	31.1%
65+	1.4%	9,236	26.5%	3.7%	\$2,341,027	4.4%
Total	100.0%	249,475	9.7%	100.0%	\$53,045,725	100.0%

Patient Count by Age Category: 2007



Payments by Age Category: 2007



BCBSM Achievement of the Cost Goal

BCBSM did not achieve the cost goal for the nurse specialists provider class as a result of increased use of services. A number of trends are responsible for the growing use of health care services nationally and in Michigan. In addition to aging of the population, the second and more important reason for rising health care costs is the rising cost of care for all age groups as a result of chronic conditions. Because persons with chronic conditions have greater health needs at any age, their costs are disproportionately high.¹¹ People with chronic conditions are the most frequent users of health care in the U.S. They account for 81 percent of hospital admissions; 91 percent of all prescriptions filled and 76 percent of all physician visits.¹²

Michigan ranks poorly on most measures of lifestyle factors and health status measures related to the development of chronic conditions, including overweight and obesity, diabetes, hypertension, cardiovascular disease, smoking and lack of physical exercise. Growing rates of obesity and chronic health conditions will fuel increased use of health care services and will continue to be a major driver of higher health care spending.

Cost Containment Programs

With the growth in chronic conditions, wellness initiatives are increasingly being used to curb rising health care costs. Because living a healthier lifestyle typically results in a reduced need for medical care, members who participate in wellness programs usually use fewer health care services in the long run, and ultimately incur lower overall health care costs. Over time, employers who put in place wellness initiatives should expect a return on their investment by incurring lower claim costs due to the improved overall health of their employees.¹³

The purpose of disease management is to empower participants so they can better manage and improve their own health while controlling costs. Highlights of BCBSM's BlueHealthConnection[®] Program are discussed below.

¹¹ "Health Care Spending and the Aging of the Population", Congressional Research Service Report for Congress, Order Code RS22619, March 13, 2007.

¹² Thorpe K. "The Rise In Health Care Spending And What To Do About It". *Health Affairs*, 2005; 6:1436-1445.

¹³ <http://blueslink.bcbsm.com/mktrain/jobaids/BHCWellnessOptionsTalkingPoints%20FINAL.PDF>.

Member-focused Health Management

BlueHealthConnection®

BCBSM's BlueHealthConnection® is an integrated care management program, addressing member needs relative to chronic conditions and health care decision support. Members have access to important clinical assistance and educational tools to help make their health care decisions.

BlueHealthConnection nurses help patients manage symptoms of minor illnesses or injuries, provide general information such as tips for healthy lifestyles or side effects of prescription drugs, manage chronic diseases, discuss treatment options, support weight loss and tobacco cessation efforts, and provide case management for the sickest one percent of the population.

BlueHealthConnection nurses advocate for the appropriate care setting for recommended services. For example, a patient with a chronic disease such as congestive heart failure may be called regularly to monitor the patient's weight. If a weight increase is noted, indicating fluid collecting in the lungs, the nurse would refer a patient to his or her physician for care or would call the patient's physician recommending administration of IV diuretics in the home. The involvement of the nurse in this example is effective because care is sought before further complications necessitate an inpatient admission and a lower cost setting for care is used.

The 2007 BCBSM BlueHealthConnection Guided Self-Management Satisfaction Survey is an annual survey used to measure users' overall satisfaction with BlueHealthConnection.¹⁴ In 2007, overall satisfaction with BlueHealthConnection remained high (90% satisfaction) and identical to 2005 and 2006. Recommendations from the 2007 survey were very positive with an emphasis on:

- ◆ Continuing to promote and expand the Blue Health Connection offerings.
- ◆ Expansion of the information available through Blue Health Connection.
- ◆ Continuing to increase the amount of information that is available over the internet (versus printed material).

With BlueHealthConnection, BCBSM has gone beyond traditional disease management and achieved a whole-person approach to care management. Members' needs are met by helping them cope with health conditions they and their loved ones are struggling to manage. This program allows BCBSM to become their health care partner and single source for health management information. Providers, including nurse practitioners, are informed about BlueHealthConnection resources available to their BCBSM patients through articles published in the *Record*.

¹⁴ <http://blueslink.bcbsm.com/spm/SP/Surveys/2007%20BHC%20Guided%20Self-Mgmt%20-%20Report.pdf>.

ACCESS GOAL PERFORMANCE

“There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.”

PA 350 Access Objectives

Objective 1

Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.

Objective 2

Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM’s record keeping requirements and the participating agreement and its administration.

Objective 3

Maintain and periodically update a printed or Web site directory of participating providers.

Performance - Access Goal and Objectives

Formal participation rates are derived by comparing the number of BCBSM participating providers to the number of providers registered with BCBSM throughout the state of Michigan. Per-claim participation is another way to measure access and rates are derived by comparing the total number of services paid in full compared to the total number of services paid.

As shown in Table 8A, BCBSM maintained a 93.8 percent combined formal participation rate in 2007 as compared to 92.8 percent in 2005. The formal participation rate for nurse specialist providers increased slightly for each specialty category during 2005 to 2007 except for certified nurse midwives, which decreased by 1.4 percent .

Certified nurse midwives and certified registered nurse anesthetist may participate on a formal or per-claim basis. Public Act 350 requires that when a provider participates on a per-claim basis for a particular procedure, he or she must continue to participate for all other cases involving that procedure for the remainder of the calendar year.

**Table 8A
Nurse Specialists Formal Participation Rates
2007-2005**

CNM

Formal Participation Rates	2007	2006	2005
Number Formally Participating	144	144	138
All Registered Providers *	146	146	138
Formal Par Rates	98.6%	98.6%	100.0%

CNP

Formal Participation Rates	2007	2006	2005
Number Formally Participating	1,456	1,299	1,119
All Registered Providers*	1,544	1,393	1,210
Formal Par Rates	94.3%	93.3%	92.5%

CRNA

Formal Participation Rates	2007	2006	2005
Number Formally Participating	1,861	1,771	1,729
All Registered Providers*	2,001	1,908	1,871
Formal Par Rates	93.0%	92.8%	92.4%

TOTAL

Formal Participation Rates	2007	2006	2005
Total Formally Participating	3,461	3,214	2,986
Total Registered Providers*	3,691	3,447	3,219
Formal Par Rates	93.8%	93.2%	92.8%

* BCBSM registered providers are used to calculate participation rates rather than Michigan licensed providers because of the inability to determine the number of licensed nurses who practice in the state.

The nurse specialists' provider participation rates ranged from 93.8 to 98.6 percent, or an average of 95.3 percent statewide during 2007 compared to 94.9 percent in 2006.

Table 8B shows the per-claim participation rates for the certified nurse midwives and certified registered nurse anesthetists during 2005 to 2007. The per-claim participation rates were stable and remained at more than 97 percent during 2005 to 2007 for each nurse specialist's category.

Table 8B
Nurse Specialists Service Benefit Rates
2007-2005

CNM

Service Benefit Rates	2007	2006	2005
Total Services Paid in Full	2,454	2,438	2,829
Total Services	2,507	2,482	2,831
Service Benefit Rates	97.9%	98.2%	99.9%

CRNA

Service Benefit Rates	2007	2006	2005
Total Services Paid in Full	248,053	239,411	225,823
Total Services	248,876	240,138	226,371
Service Benefit Rates	99.7%	99.7%	99.8%

The statewide combined participation rate for nurse specialists for 2007 was 94 percent compared to 93 percent in 2006 as shown in Table 9. The regional participation rate was 80 percent or greater in all of the regions statewide except for region nine. This region had a average participation rate of 70 percent during 2007 and 2006. The 2007 participation rate for this region was the result of an average participation rate of 98 percent for CNPs and 50 percent for CRNAs as shown in appendix C1 and C2 respectively. While the average par rate for CRNAs in region nine was lower than in all other regions, the number of registered CRNAs increased from 54 in 2006 to 58 in 2007, and the per-claim participation rate for these providers was 99.7 percent (see appendix C3).

There are no CNMs registered or participating in region nine, and according to data provided by the Michigan Department of Community Health Board of Health Professions, there are only 2 CNMs licensed in this region. The data does not indicate if the nurses are employed, but does indicate that they are active and able to practice. Nurses sometimes maintain their license but may be employed in occupations other than nursing.

**Table 9
Nurse Specialists Detailed Reports
2007-2006 Access by Region**

COMBINED NURSE SPECIALISTS DETAILED REPORT BY REGION

Region	2007			2006		
	Number of Participating Providers	Total Registered Providers*	Participation Rate	Number of Participating Providers	Total Registered Providers*	Participation Rate
1	1,654	1,714	96%	1,523	1,580	96%
2	371	391	95%	350	372	94%
3	175	179	98%	166	168	99%
4	184	191	96%	178	184	97%
5	297	367	81%	273	343	80%
6	290	311	93%	267	293	91%
7	267	278	96%	245	256	96%
8	152	159	96%	146	158	92%
9	71	101	70%	67	94	71%
Statewide	3,461	3,691	94%	3,215	3,448	93%

* BCBSM registered providers are used to calculate participation rates rather than Michigan licensed providers because of the inability to determine the number of licensed nurses who practice in the state.

Chart 5 on page 29 provides a regional map defining the PA 350 regions and shows the 2007 distribution of participating nurse specialist providers, all specialties by county. Below are the main factors that helped achieve the access goal, which are highlighted in this section:

- ◆ Provider communication via BCBSM publications, on-line assistant tools, and provider consultants
- ◆ BCBSM’s reimbursement methodologies for nurse specialist providers

Provider Communications

Enhanced channels of communication helped establish and maintain a good rapport with participating providers.

Publications and Services

BCBSM distributes to all providers a publication called *The Record*. It is a monthly source that communicates billing, reimbursement, group-specific benefit changes, and day-to-day business information from BCBSM. *The Record* was created with input from provider focus groups as an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them.

In January 2007, BCBSM added “Record Select”, an on-line service that allows providers to select pertinent articles by category. The articles are compiled monthly and held until BCBSM

notifies the providers through e-mail when the articles are available. The articles can be reviewed online or downloaded and saved to a personal computer. More than 2,000 providers have signed up for this service and a specific article category has been created for each certified nurse specialty.

Participating nurse specialists' can access a comprehensive online provider manual on web-DENIS, which contains detailed instructions for servicing BCBSM members. The manual is updated as necessary allowing nurse specialists' to obtain information on a real time basis. Topics detailed in the manual include:

- ◆ Member eligibility requirements
- ◆ Benefits and exclusions
- ◆ Criteria guidelines for services
- ◆ Documentation guidelines
- ◆ Claim submission information
- ◆ Appeals process
- ◆ Utilization review
- ◆ BCBSM departments to contact for assistance

BCBSM offers providers the options of speaking with provider service representatives, writing to our inquiry department, and having a provider consultant visit provider offices to help guide and educate their staffs. BCBSM trainers educated providers with seminars on various topics such as how to use web-DENIS, benefits, claims processing, adjustments, InterQual® and Medicare Advantage. Computer based training tools have also been developed to expand the reach of the training sessions.

Inquiry Systems

Web-DENIS, an electronic inquiry system, gives providers online access to health insurance information for BCBSM members via Internet connection. This system expanded from a private access network of electronic self-service features supporting provider inquires to an Internet-based program via a new secured provider portal on www.bcbsm.com. This program offers quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, reports and much more information needed to make doing business with BCBSM easier. BCBSM designed the Internet site to promote secure, effective, and personalized use of the Internet for existing web-DENIS users and to encourage new providers to begin to use web-DENIS.

Web-DENIS also has *Partner Links* that connect providers to BCBSM's partner sites, including the Council for Affordable Quality Healthcare, Institute for Safe Medication Practices, Michigan State Medical Society and the Michigan Health and Hospital Association.

During August 2005, BCBSM implemented the Internet Claims Submission Tool through web-DENIS. The tool allows providers who currently submit paper claims to submit them online for processing. This tool provides a low cost alternative to smaller practices that are not interested

in purchasing expensive software to bill electronically through conventional means. In addition to its convenience and cost savings, the Internet Claims Submission Tool offers providers a faster response time than paper claims

In March 2007, web-DENIS added capability to respond to requests from providers for specific service type information regarding members of other BCBS plans. As a result, a provider can request and receive specific member benefit information, such as eligibility, benefit limitations, patient liability and coverage by place of service.

Another avenue for nurse specialists to obtain needed information from BCBSM is CAREN⁺, an integrated voice response system which provides information on eligibility, benefits, deductibles and copayments. In 2006 CAREN⁺ was enhanced to include interactive voice response technology that enables providers to enter contract numbers by voice or text.. In addition, security measures were added to CAREN⁺ to safeguard our members' protected health information.

BCBSM's ongoing communication with providers enhanced relationships with them and improved formal participation.

Reimbursement

BCBSM's reimbursement methodology is designed to be equitable while maintaining appropriate participation levels. BCBSM reimburses participating nurse specialists for covered services deemed medically necessary by BCBSM, as described in Addendum A of the CNM, CNP and CRNA participation agreements. The agreements are contained in Appendix E of this document.

Reimbursement policies differ for certified nurse specialty providers as described on page 4-5 of this report. BCBSM will periodically review certified nurse midwife, certified nurse practitioner and certified registered nurse anesthetist providers' reimbursement to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

Provider Programs

Provider Affiliation Strategy Programs

BCBSM's provider affiliation strategy is a fundamental approach to doing business that fosters an ongoing commitment to excellent performance and dialogue with providers. To better serve our communities and customers, BCBSM promotes business relationships with providers so they will:

- ◆ Collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care
- ◆ Help BCBSM deliver outstanding customer service to members
- ◆ Value BCBSM as a health plan of choice and recommend it to patients and others

The Provider Affiliation Strategy focuses on the following key elements that support a strong relationship with providers:

- ◆ Prompt and accurate claims payment
- ◆ Consistent, accurate and responsive service
- ◆ Timely and effective communication
- ◆ Partnerships to promote and facilitate better health care

Prompt, Accurate Claims Payment

BCBSM initiated programs to improve the quality and timeliness of system changes to improve the percentage of claims reimbursed on the first submission. At the same time, BCBSM also initiated a process to reduce the number of initial claim rejections.

BCBSM's adjustment rate initiative was designed to reduce the number of claims that are manually adjusted to process through BCBSM's claim system. During 2006, claim rejections were reduced by 30 percent in select claim categories. The reduction is the result of clarification of billing and reimbursement guidelines, removal of unnecessary edits and standardization of medical policy rejections.

Responsive Service

BCBSM's Provider Consulting Services increased provider satisfaction by building relationships through enhanced visibility, communication and consultative services. Provider consultants advocate for the priority and resolution of issues identified by providers to assure their needs are communicated to and acted upon by BCBSM. Consultants assisted nurse specialists with complex billing issues, answered their benefit questions and educated their staffs on billing policies and procedures. Consultants also provided written materials that may help providers' staffs in their daily work.

During 2007, BCBSM added more professional fee schedules on web-DENIS to assist providers to conduct business more efficiently. In addition, improvements were made to answer provider calls faster, which reduced wait time to less than sixty seconds.

Effective Communications

During June to August 2007, BCBSM increased face to face feedback opportunities through provider outreach fairs. The fairs were held throughout the state, giving providers the opportunity to interact with BCBSM representatives, to discuss web-DENIS, provider training, electronic data interchange and other topics. In 2006 and 2007 more than 2000 providers attended the fairs.

During 2007, the provider section of the BCBSM Web site was redesigned for easier navigation. New features were added, such as online registration for seminars and national provider identifier reporting. In addition, self-paced on-line training modules with interactive animation and learning exercises, designed to guide providers on how to use electronic provider manuals, benefit detail records, maximum fee schedules and other resources were added.

QUALITY OF CARE GOAL PERFORMANCE

“Providers will meet and abide by reasonable standards of health care quality.”

PA 350 Quality of Care Objectives

Objective 1

Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM’s qualification and performance standards.

Objective 2

Meet with specialty liaison societies to discuss issues of interest and concern.

Objective 3

Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes regarding utilization review audits.

Performance - Quality of Care Goal and Objectives

BCBSM’s approach to achieving the quality of care objective for the nurse specialists provider class is to:

- ◆ Ensure the quality of care by enforcing qualification standards for participation
- ◆ Maintain quality controls through utilization management and audits
- ◆ Implement quality management initiatives that promote safety, improve the health of the community and ensure the delivery of high quality health care
- ◆ Develop strong relationships with participating providers by offering them various avenues to receive information and to voice concerns

Qualification Standards

All nurse specialists may apply to participate with BCBSM. Nurse specialists who participate formally or per-claim must meet basic standards in addition to the specific qualification standards that apply to their specialties. These basic standards include, but are not limited to:

- ◆ A current Michigan license as a registered nurse¹⁵
- ◆ Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review
- ◆ Absence of fraud and illegal activities
- ◆ Each nurse specialist must also meet the following additional standards that apply to their specialty

Certified Nurse Midwives

A CNM must have and maintain:

- ◆ Current national certification by the American College of Nurse Midwives, American Midwifery Certification Board or another nationally recognized nurse midwife certifying entity recognized by the Michigan Board of Nursing
- ◆ Current nurse midwife specialty certification issued by the Michigan Board of Nursing

For CNMs performing deliveries, the following items are also required:

- ◆ Written confirmation of an established relationship for medical consultation, collaboration or referral with an obstetrician-gynecologist (OB-GYN) or a qualified physician, if access to an OB-GYN is not available. A qualified physician is an MD/DO such as a perinatologist, family practice physician or internist with a women's health practice that corresponds to that of the CNM. The OB-GYN or otherwise qualified physician must have OB-GYN admitting privileges at the hospital or hospital-affiliated birthing center where the CNM will practice.
- ◆ Written confirmation of established privileges with hospital(s), or hospital-affiliated birthing center(s), or written confirmation of emergency and hospital admission arrangements with a consultant physician who has admitting privileges.

Certified Nurse Practitioners

A CNP must have and maintain:

- ◆ Current certification by a nationally recognized certifying entity recognized by the Michigan Board of Nursing. This presently includes the following:
 - ◆ American Nurses Credentialing Center
 - ◆ National Certification Corporation for the Obstetric-Gynecologic and Neonatal Nursing Specialties
 - ◆ Pediatric Nursing Certification Board
 - ◆ American Academy of Nurse Practitioners
 - ◆ Oncology Nursing Certification Corporation

¹⁵ BCBSM verifies licensure regularly with the state of Michigan.

- ◆ Current nurse practitioner specialty certification issued by the Michigan Board of Nursing

Certified Registered Nurse Anesthetics

A CRNA must have and maintain:

- ◆ Current national certification from the Council on Certification of Nurse Anesthetists or current recertification from the Council on Recertification of Nurse Anesthetists
- ◆ Current nurse anesthetist specialty certification issued by the Michigan Board of Nursing¹⁶

Quality Controls

BCBSM strives to ensure members receive appropriate and quality care through a combination of quality assurance programs.

Performance Monitoring

BCBSM enforced licensure requirements and qualification standards through the provider credentialing process. In order to participate, nurse specialists must have a Michigan license and a specialty certification from the Michigan Board of Nursing. Nurses must also be certified by a national nursing organization as a nurse midwife, nurse practitioner, or nurse anesthetist.

BCBSM ensured current licensure through a licensing verification process using the Michigan Department of Community Health Website. This agency also sent BCBSM lapsed license electronic data files weekly. The files were compared to the BCBSM provider database to ensure that providers with lapsed licenses were removed from the database.

Audits

BCBSM's retrospective utilization management process was available for nurse specialists to evaluate whether individual providers rendered services in accordance with BCBSM's benefits and policies.

Typically audits are not routinely conducted for provider classes whose payout is considerably lower than that of other types of providers. In these cases, BCBSM relies on subscriber complaints or unusual claims that suggest deviation from standard practice patterns or noncompliance with member benefits. There was no nurse specialist audit activity to report during this reporting period.

¹⁶ Once a CRNA obtains specialty certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA received national certification from the Council on Certification of Nurse Anesthetists. This applies to newly certified CRNAs only. A recertified CRNA's participation contract will be effective on the date it is issued.

Departicipation Policy

A departicipation policy allows BCBSM to departicipate a provider after review and recommendation for departicipation by the BCBSM Audit and Investigations Subcommittee. This policy is described further in Addendum I of the CNM, CNP and CRNA participation agreements.

Quality Management Initiatives

The goal of BCBSM's social mission is to improve the health status of Michigan residents by focusing resources on areas of greatest importance where BCBSM is uniquely positioned to deliver results. Healthier residents should consequently reduce health care costs.

BCBSM executed and publicized health initiatives that address the root causes of critical health issues such as:

- ◆ Community programs addressing geographic, racial and ethnic disparities
- ◆ Programs designed to improve the health status of children (e.g., immunization rates, pediatric healthy weight toolkit, adequate prenatal care, physical fitness and healthy food choices)
- ◆ Programs designed to address obesity
- ◆ Smoking cessation programs
- ◆ Depression awareness
- ◆ Domestic violence and abuse

BCBSM sponsors programs such as *WalkingWorks*[™], a wellness program designed to promote good health, and *Healthy ME!*[™], a free program for Michigan elementary schools that blends facts about healthy lifestyles with friendly characters, upbeat songs and humor. By encouraging the adoption of healthier, more active lifestyles, these programs will help control costs in the future.

BCBSM also offers a 24-Hour Nurse Line. The 24-Hour Nurse Line services members who are engaged in preventive health efforts, interested in making decisions about acute health issues related to injury or illness, or managing less complex medical conditions. The goal of the helpline is to educate members about health issues, disease management, and community resources. Health coaches provide members with assistance in managing their symptoms and making informed decisions about their health care.¹⁷

In addition, Blue Cross Blue Shield of Michigan has one of the largest repositories of health care utilization data in the United States. BCBSM plays a key role in bringing health care value to our customers and the community by utilizing our abundant source of data for health research and analysis.

¹⁷ http://blueslink.bcbsm.com/mcmo/divisional/a/cpmi_units.html.

BCBSM's analysis of local data has led to successful partnerships with area health systems, health coalitions and community health initiative programs.¹⁸ Examples of these collaborative efforts include the Michigan Quality Improvement Consortium and the Michigan Health and Safety Coalition.

The Michigan Quality Improvement Consortium is a group of health plans, physicians, quality improvement organizations and medical societies that works to develop a single source of quality improvement guidelines for the treatment of certain conditions and the measuring of health care provider performance.¹⁹

The Michigan Health and Safety Coalition leads and supports a diverse group of providers, including nurses, that work to develop solutions to patient safety problems. In 2004, Governor Jennifer Granholm asked this coalition to be Michigan's Commission on Patient Safety.²⁰

Today, data management and clinical analysis of health care information are critical components of being a market leader. By providing those elements, the Blues positively impact the quality of care in the community and support our mission of excelling in the delivery of health care products and services.²¹

Provider Relations

During this review period, BCBSM maintained effective relations with nurse specialists through a liaison committee, provider education and a formal appeals process.

Liaison Committee

Effective provider communications helped BCBSM and nurse specialists to address issues that affect the quality of care rendered to members.

BCBSM met with the Michigan Nurses Association twice in 2006 and once in 2007 discussing indirect CNP billing guidelines and CNM reimbursement and scope of practice issues.

Provider Education

BCBSM offered continuing nurse education seminars regularly, with the goal of having a positive impact on nursing practices and patient outcomes. The seminars offered an opportunity for participating nurse specialists to obtain current clinical information on important topics. Topics in 2006 included managing migraine pain, a diabetes and endocrine update, women's cardiovascular health, autoimmune disease update, best practices, and updates on pharmacy and avian flu. Topics for 2007 provided education on pain management, thyroid function and disorders, diet and exercise, hepatitis C, rheumatoid arthritis, Crohn's disease and preventive

¹⁸ http://www.bcbsm.com/home/commitment/research_quality_improvement.shtml.

¹⁹ http://blueslink.bcbsm.com/ca/pdf/bcbsm_report_to_community_2007.pdf.

²⁰ http://blueslink.bcbsm.com/ca/pdf/bcbsm_report_to_community_2007.pdf.

²¹ http://www.bcbsm.com/home/commitment/research_quality_improvement.shtml.

dental care. Attendance for the 2007 continuing education seminars was approximately 1,700 registered nurses.

Appeals Process

BCBSM's appeals process allows providers the right to appeal adverse claim decisions and utilization review audit determinations. The process is described in Addendum E of the CNM, CNP and CRNA participation agreements. There were no requests for OFIR determinations received during the 2006-2007 reporting period.

CONCLUSION

Cost Goal

The cost goal for the nurse specialists provider class was not met since overall nurse specialists payments increased an average of 7.8 percent during the reporting period. This increase was primarily attributable to higher utilization of anesthesia services. Nurse specialists payments will continue to grow as the prevalence of chronic diseases and an aging population fuel increased demand for health care services, while technological advances continue to escalate the cost of care.

Access Goal

BCBSM met the access goal for the nurse specialists provider class. BCBSM offered licensed and certified nurse specialists the opportunity to participate by signing a formal participation agreement. Certified nurse midwives and certified registered nurse anesthetists were also able to participate on a per-claim basis, resulting in an average of 98.8 services being paid in full. In region nine where there were fewer CRNAs, the participation rate was lower, but the per-claim participation rate for CRNA services was 99.7 percent. This level of participation minimized out-of-pocket expenses for members. Effective provider communications, BCBSM's reimbursement methodology and responsive service all helped achieve the access goal.

Quality of Care Goal

BCBSM achieved the quality of care goal. Nurse specialists were required to meet qualification standards to ensure they were capable of providing high quality care to BCBSM members. Quality controls, which included performance monitoring, potential audits and departicipation guidelines, ensured that services rendered were administered by a licensed provider, medically necessary, appropriate for the patient's condition and in accordance with the participating agreement. Quality management initiatives publicized health initiatives that addressed the root causes of critical health issues such as programs for obesity, smoking cessation, depression awareness, domestic violence and pediatric health status. The Michigan Quality Improvement Consortium and the Michigan Health and Safety Coalition were also part of BCBSM's response to improving health status. Finally, BCBSM offered nurse specialists several means to maintain effective relations, including liaison committee meetings, provider education and a provider's appeals process.

APPENDIX A

Overview of Public Act 350

This section briefly describes the provider class plan annual reporting requirements mandated under Public Act 350.

Annual reporting requirements

The provider class plan annual reports are submitted pursuant to section 517 of PA 350, which requires BCBSM to submit to the Commissioner an annual report for each provider class that shows the level of BCBSM's achievement of the goals provided in section 504.

PA 350 Goals

The term "goals", used in section 517 above, refers to specific cost, access and quality goals described in section 504. This section states:

"A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of health care services in accordance with the following goals:

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\frac{((100 + I) \times (100 + REG))}{(100)} - 100$$

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Quality of Health Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Calculation of 2006 – 2007 Cost Goal

P.A. 350 Cost Goal Formula

The P.A. 350 cost goal formula , as stated in the Act is:

$$\frac{((100 + I) X (100 + REG))}{100} - 100$$

Goal Calculations (see attached sheet for yearly indicators)

<u>Year of Determination</u>	<u>2008</u>
I (CY 2007 - 2006)	2.654% (matches the CPI closely)
REG (CY 2007 - 2004)	1.925%

Applying these indices into the formula, the cost goal becomes:

$$\frac{((100 + I\%) X (100 + REG\%))}{100} - 100 = \mathbf{4.579\%}$$

PA 350 Cost Goal Assumptions

Year	Population (1)	Real GNP (2)	Per Capita GNP	Implicit GNP Price Deflator (3)	Percent Change	
					PC GNP	IPD
2003	290,116,000	\$ 10,540,500,000,000	\$ 36,332.02	107.18		
2004	292,801,000	\$ 10,844,400,000,000	\$ 37,036.76	110.67	1.940%	3.252%
2005	295,507,000	\$ 11,151,100,000,000	\$ 37,735.49	114.38	1.887%	3.360%
2006	298,217,000	\$ 11,447,800,000,000	\$ 38,387.48	117.51	1.728%	2.734%
2007	300,913,000	\$ 11,799,100,000,000	\$ 39,211.00	120.54	2.145%	2.573%

(1) Population projections based on 2000 census released May 11, 2004
www.census.gov/ipc/www/usinterimproj/usproj_detail_file_RTT (Total Resident Population)

(2) <http://research.stlouisfed.org/fred2/series/GNPC96/downloaddata?cid=106>

(3) <http://research.stlouisfed.org/fred2/series/GNPDEF/downloaddata?cid=21>

Definitions

Section 504 of the Act also provides the following definitions for terms used in the cost goal calculation:

“ ‘Gross National Product (GNP) in constant dollars’ means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis.”

“ ‘Implicit price deflator for gross national product’ means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis.”

“ ‘Inflation’ (I) means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.”

“ ‘Compound rate of inflation and real economic growth’ means the ratio of the quantity 100 plus inflation multiplied by the quantity 100 plus real economic growth to 100; minus 100.”

“ ‘Rate of change in the total corporation payment per member to each provider class’ means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the Commissioner's determination.”

“ ‘Real economic growth’ (REG) means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.”

Determination Process

Under PA 350, the commissioner is required to consider information presented in the annual report, as well as all other relevant factors that might affect the performance of a particular provider class, in making a determination with respect to that class.

Section 509 of the Act outlines factors that should be considered by the commissioner to “determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan.” Many of these factors are beyond BCBSM's direct control and may adversely impact the cost and use of health care services for a particular provider class. Specifically, section 509(4) states:

The commissioner shall consider all of the following in making a determination...:

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on one goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning:

- ◆ *Demographic trends;*
- ◆ *Epidemiological trends;*
- ◆ *Long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d);*
- ◆ *Sudden changes in circumstances;*
- ◆ *Administrative agency or judicial actions;*
- ◆ *Changes in health care practices and technology; and,*
- ◆ *Changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.*

(d) Health care legislation of this state or of the federal government. As used in this subdivision, 'health care legislation' does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in sections 504, and the objectives contained in the provider class plan, the commissioner shall determine one of the following [as stated under section 510(1)]:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve one or more of the goals of the corporation as provided in section 504.

A determination made by the commissioner under section 510 1(a) or 1(b) would require no further action by the corporation. Upon a 511(1)(c) determination by the commissioner, under section 511, the corporation:

(1) Within 6 months or a period determined by the commissioner..., shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

If after 6 months or a period determined by the commissioner..., the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan..., for that provider class.

The findings of the commissioner may be disputed by any party through an appeals process available under section 515 of PA 350.

APPENDIX B

Technical Notes

The data indices presented in the 2005, 2006, and 2007 databases and analyzed in the annual reports reflect a defined subset of BCBSM claims experience. The data specifications and collection methodologies are discussed in the following sections.

Data Elements and Collection

The basic statistics analyzed for each provider class are total payments and utilization, from which an average price per utilization unit is derived. These data were collected from BCBSM data files that are based on claims submitted to the Corporation and approved for payment to the provider or in some cases, the subscriber.

The data collection period captures health care services incurred during specific twelve-month calendar years and paid through fourteen months. For example, the 2007 dataset includes all services incurred between 1/1/07 and 12/31/07, and paid from 1/1/07 through 2/28/08. It is reasonable to expect that for facility provider classes, over 97 percent of total experience is captured.

Participation rates are based on providers who sign a BCBSM participation agreement and the total number of licensed providers registered with BCBSM.

Scope of the Data

Provider Class Accountability

PA 350 requires BCBSM to report its Traditional product for the purposes of provider class accountability. However, for the ancillary provider classes, including pharmacy, BCBSM's PPO experience is included. BCBSM membership systems capture members' product line information only once, reflecting the member's hospital/medical-surgical coverage (e.g., a member with PPO pharmacy coverage but Traditional hospital/medical-surgical coverage is considered a Traditional member). The following providers do not have a PPO network therefore Traditional and PPO members are both reported:

- ◆ Skilled nursing facilities
- ◆ Substance abuse facilities
- ◆ Home health care facilities
- ◆ Outpatient psychiatric care facilities
- ◆ Outpatient physical therapy facilities
- ◆ Ambulatory surgical facilities
- ◆ Hospice providers
- ◆ DME-P&O providers
- ◆ Ambulance providers

- ◆ Home infusion therapy providers
- ◆ Nurse specialists (CRNA, CNM, CNP)

Underwritten groups and administrative services contract groups are included. For ancillary provider classes, complementary claims and membership data is included. The data excludes the Federal Employee Program and non-Michigan liability such as claims paid through the Inter-Plan Teleprocessing System for out-of-state Blue members. Claims incurred out-of-state by BCBSM members are also excluded.

Blue Care Network data are excluded from the reporting requirements referred to in PA 350 Section 502(a) (11) and the HMO Act.

Regional Experience

Regions selected for analysis are compatible with Michigan Metropolitan Statistical Areas (MSAs) and provide an acceptable basis for analysis of access as well as of provider practice patterns. Regions one through nine represent groups of Michigan counties. Michigan claims experience with unidentified zip codes was allocated among the nine regions according to the distribution of data with identifiable zip codes.

Membership

This report includes all BCBSM Traditional members and PPO members, where applicable by provider class, residing in Michigan.

The regions used for analysis pertain to the location where services were delivered. For example, region one experience represents payments to region one providers for services rendered to BCBSM members regardless of residency. This is because subscribers who live in one region may receive services in another region because they reside near a border or want services from a provider in another region.

APPENDIX C

Supporting Tables and Charts

Table # found in body	Appendix #	Description
Table 1	C1	2007 Certified Nurse Midwives Detailed Report by Region
	C2	2007 Certified Nurse Practitiners Detailed Report by Region
	C3	2009 Certified Registered Nurse Anesthetists Detailed Report by Region
Chart 3	C4	2007 Certified Nurse Midwives Provider Class Payments by Location of Service
	C5	2007 Certified Nurse Practitioner Provider Class Payments by Location of Service
	C6	2007 Certified Registered Nurse Anesthetists Provder Class Payments by Location of Service
Table 6	C7	2007 Certified Nurse Midwives Provider Class Payments by Region
	C8	2007 Certified Nurse Practitioner Provider Class Payments by Region
	C8	2007 Certified Registered Nurse Anesthetists Provder Class Payments by Region
Table 7	C10	2007 Nurse Specialists Provider Classes Membership by Age Category

**Appendix C1
BCBSM Certified Nurse Midwives
Detailed Report by Region 2007**

CERTIFIED NURSE MIDWIVES DETAILED REPORT BY REGION

Region	2007			2006		
	Number of Participating Providers	Total Registered Providers*	Participation Rate	Number of Participating Providers	Total Registered Providers*	Participation Rate
1	42	44	95%	49	51	96%
2	24	24	100%	22	22	100%
3	3	3	100%	5	5	100%
4	5	5	100%	5	5	100%
5	39	39	100%	36	36	100%
6	11	11	100%	8	8	100%
7	10	10	100%	10	10	100%
8	10	10	100%	10	10	100%
9	0	0	0%	0	0	0%
Statewide	144	146	99%	145	147	99%

* BCBSM registered providers are used to calculate participation rates rather than Michigan licensed providers because of the inability to determine the number of licensed nurses who practice in the state.

**Appendix C2
BCBSM Certified Nurse Practitioners
Detailed Report by Region 2007**

CERTIFIED NURSE PRACTITIONERS DETAILED REPORT BY REGION

Region	2007			2006		
	Number of Participating Providers	Total Registered Providers*	Participation Rate	Number of Participating Providers	Total Registered Providers*	Participation Rate
1	497	527	94%	414	443	93%
2	240	251	96%	225	236	95%
3	63	65	97%	61	62	98%
4	75	80	94%	70	75	93%
5	137	155	88%	124	141	88%
6	193	206	94%	174	192	91%
7	112	115	97%	102	103	99%
8	97	102	95%	92	101	91%
9	42	43	98%	37	40	93%
Statewide	1,456	1,544	94%	1,299	1,393	93%

* BCBSM registered providers are used to calculate participation rates rather than Michigan licensed providers because of the inability to determine the number of licensed nurses who practice in the state.

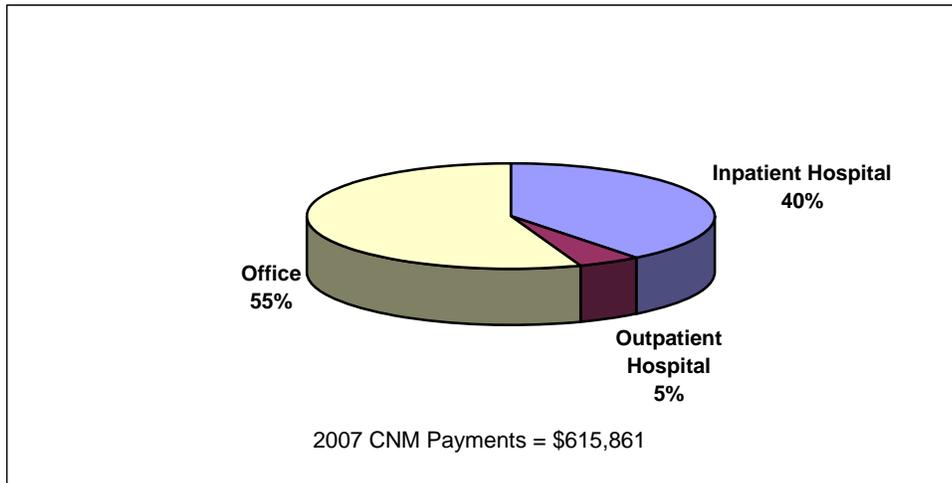
Appendix C3
BCBSM Certified Registered Nurse Anesthetists
Detailed Report by Region 2007

CERTIFIED REGISTERED NURSE ANESTHETISTS DETAILED REPORT BY REGION

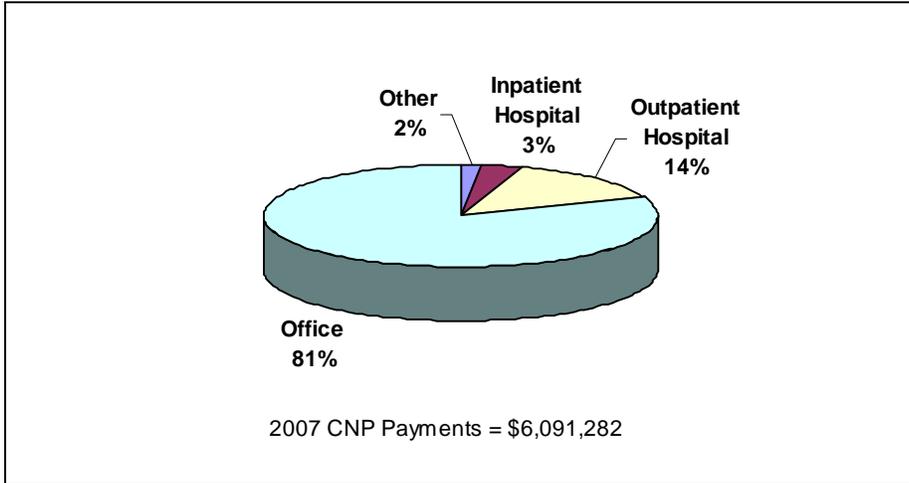
Region	2007			2006		
	Number of Participating Providers	Total Registered Providers*	Participation Rate	Number of Participating Providers	Total Registered Providers*	Participation Rate
1	1,115	1,143	98%	1,060	1,086	98%
2	107	116	92%	103	114	90%
3	109	111	98%	100	101	99%
4	104	106	98%	103	104	99%
5	121	173	70%	113	166	68%
6	86	94	91%	85	93	91%
7	145	153	95%	133	143	93%
8	45	47	96%	44	47	94%
9	29	58	50%	30	54	56%
Statewide	1,861	2,001	93%	1,771	1,908	93%

* BCBSM registered providers are used to calculate participation rates rather than Michigan licensed providers because of the inability to determine the number of licensed nurses who practice in the state.

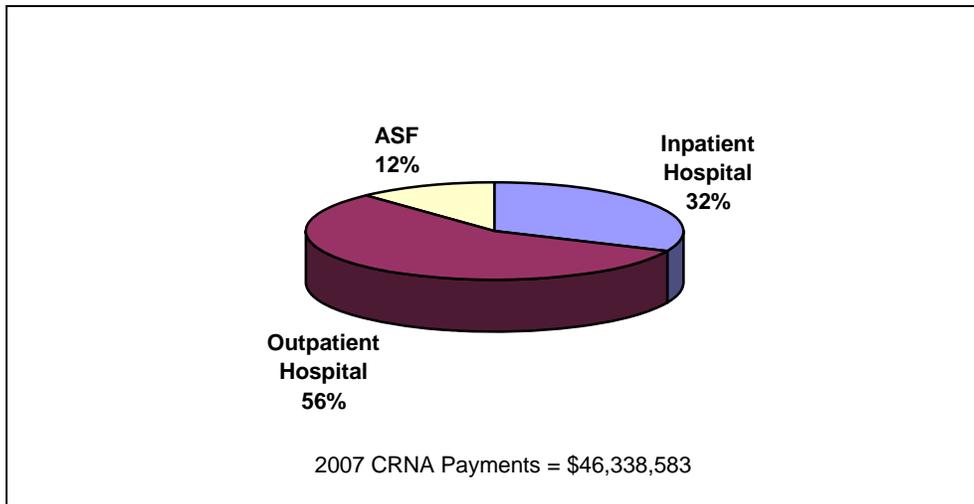
Appendix C4
Certified Nurse Midwives Payments by Location of Service: 2007



Appendix C5
Certified Nurse Practitioners Payments by Location of Service: 2007



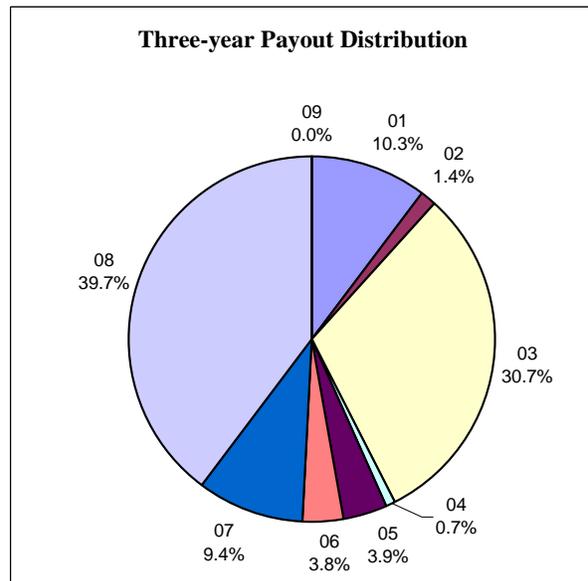
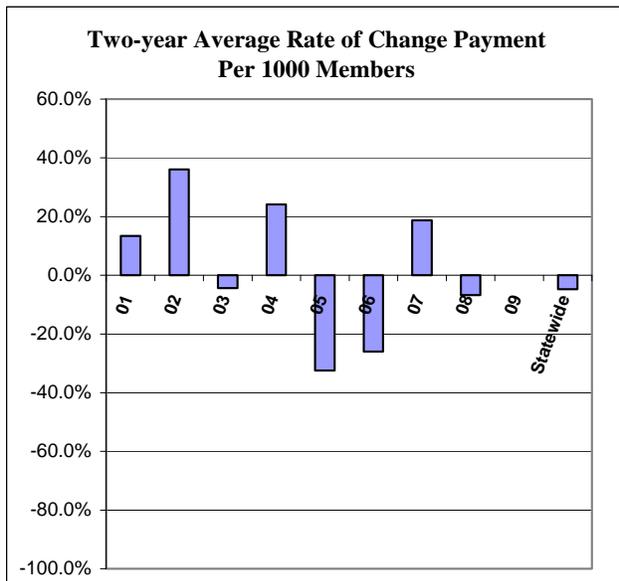
Appendix C6
Certified Registered Nurse Anesthetists Payments by Location of Service: 2007



**Appendix C7
Certified Nurse Midwives Provider Class Payments by Region**

CERTIFIED NURSE MIDWIVES PROVIDER CLASS

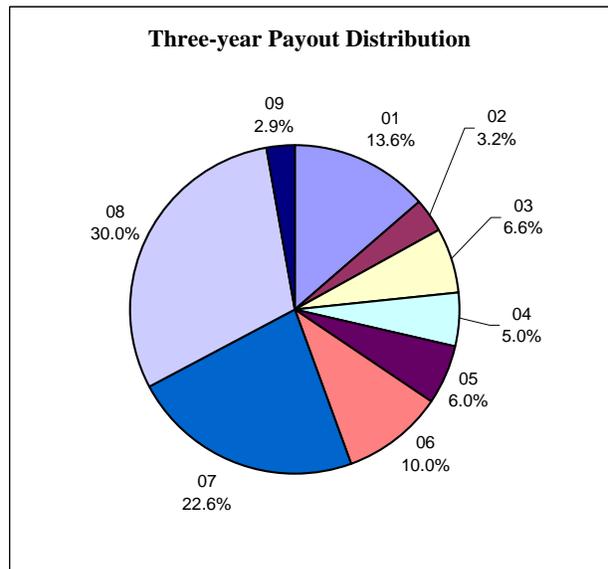
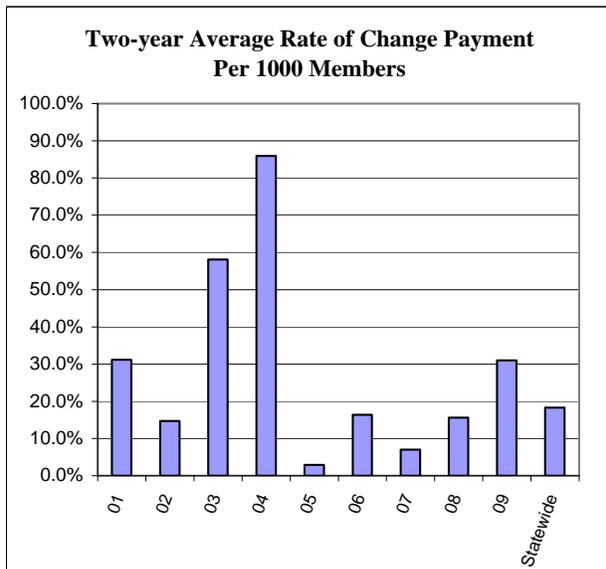
Region	Two-year Average Rate of Change			Three-year Payout	% of Total Payout
	Payments Per 1000 Members	Services Per 1000 Members	Payment Per Service		
01	13.4%	46.8%	-23.7%	\$ 202,205	10.3%
02	36.1%	138.5%	-35.9%	\$ 27,419	1.4%
03	-4.4%	-16.0%	13.9%	\$ 601,078	30.7%
04	24.1%	7.7%	23.0%	\$ 14,387	0.7%
05	-32.5%	-34.6%	0.5%	\$ 75,900	3.9%
06	-26.0%	-24.4%	16.9%	\$ 73,755	3.8%
07	18.7%	1.5%	16.4%	\$ 183,770	9.4%
08	-6.7%	7.1%	-9.7%	\$ 776,487	39.7%
09	N/A	N/A	N/A	\$ -	0.0%
Statewide	-4.8%	-3.7%	-1.0%	\$ 1,955,001	100.0%



**Appendix C8
Certified Nurse Practitioners Provider Class Payments by Region**

CERTIFIED NURSE PRACTITIONERS PROVIDER CLASS

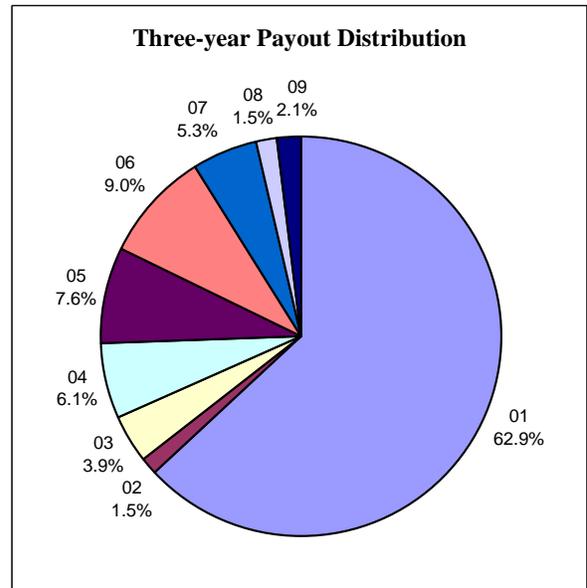
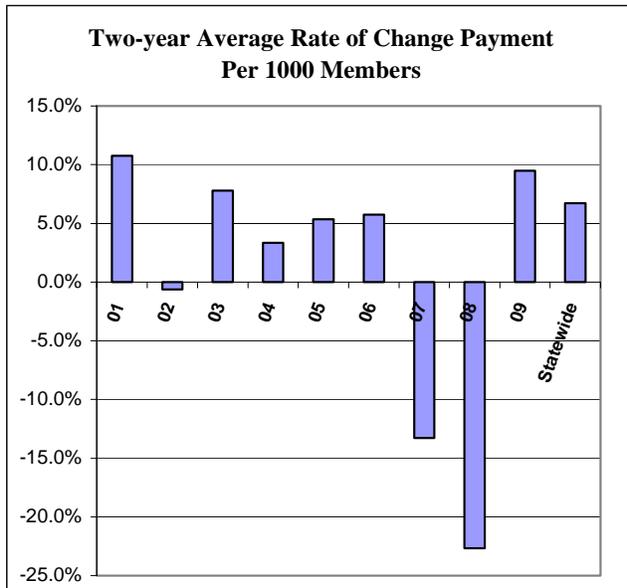
Region	Two-year Average Rate of Change			Three-year Payout	% of Total Payout
	Payments Per 1000 Members	Services Per 1000 Members	Payment Per Service		
01	31.1%	25.6%	4.5%	\$ 2,054,362.43	13.6%
02	14.7%	-10.3%	36.6%	\$ 488,130.08	3.2%
03	58.1%	40.8%	11.3%	\$ 1,002,938.11	6.6%
04	85.9%	21.2%	58.6%	\$ 758,867.94	5.0%
05	2.9%	-1.3%	4.4%	\$ 906,351.51	6.0%
06	16.4%	3.4%	12.2%	\$ 1,512,660.53	10.0%
07	7.0%	2.6%	4.0%	\$ 3,423,106.79	22.6%
08	15.6%	11.8%	3.4%	\$ 4,533,149.77	30.0%
09	31.0%	12.8%	15.0%	\$ 436,759.21	2.9%
Statewide	18.3%	8.7%	8.8%	\$15,116,326.37	100.0%



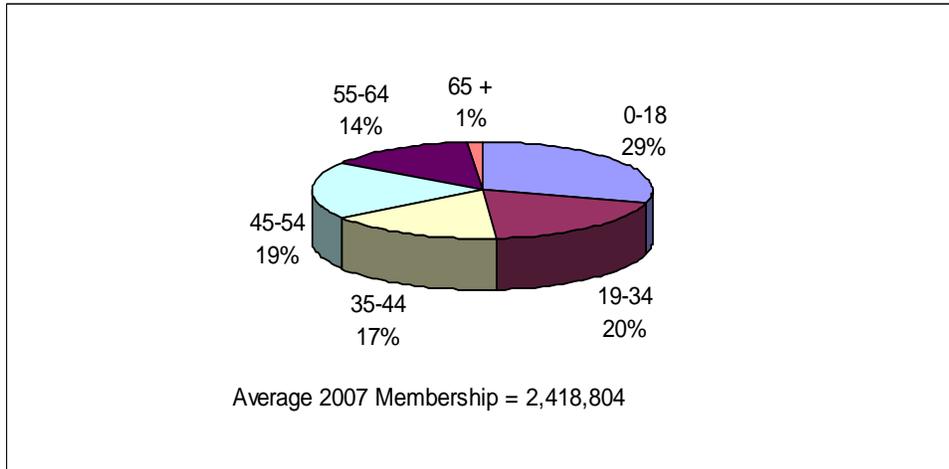
**Appendix C9
 Certified Nurse Anesthetists Provider Class Payments by Region**

CERTIFIED REGISTERED NURSE ANESTHETISTS PROVIDER CLASS

Region	Two-year Average Rate of Change			Three-year Payout	% of Total Payout
	Payments Per 1000 Members	Services Per 1000 Members	Payment Per Service		
01	10.8%	8.8%	1.7%	\$82,727,749	62.9%
02	-0.6%	0.3%	-1.0%	\$2,021,250	1.5%
03	7.8%	4.1%	3.5%	\$5,139,625	3.9%
04	3.4%	3.5%	0.1%	\$8,079,317	6.1%
05	5.4%	-0.3%	5.8%	\$10,053,187	7.6%
06	5.7%	3.4%	2.3%	\$11,822,079	9.0%
07	-13.3%	-12.6%	-0.7%	\$6,954,249	5.3%
08	-22.7%	-23.1%	1.0%	\$1,963,712	1.5%
09	9.5%	8.5%	0.9%	\$2,695,056	2.1%
Statewide	6.7%	5.1%	1.5%	\$131,456,224	100.0%



Appendix C10
Nurse Specialists Provider Classes
Membership by Age Category: 2007



APPENDIX E – Participation Agreements (Attached)

Nurse Specialists Participation Agreements