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Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

A quarterly newsletter for hospitals and institutional ancillary providers

SPRING 2013

Healthbox Kicks Off Second Boston Accelerator Program

Healthbox—a company that fosters innovation and entrepreneurship in the health care industry—recently kicked off of its second Healthbox Boston program. Blue Cross Blue Shield of Massachusetts will continue its partnership with Healthbox in 2013 as part of our commitment to address health care challenges.

This year, Healthbox will give ten new health care innovation start-ups a chance to fast-track their growth by offering them access to resources, support, and an expert network.

Healthbox funds entrepreneurs

Healthbox has invited entrepreneurs with early-stage health care technology-enabled startups to apply. These companies will receive up to $50,000 in seed capital and will participate in an intensive 16-week program. The companies will be based in Healthbox's Boston office, where they will receive strategic guidance from leading industry experts and learn how to grow their companies in a complicated industry.

"Blue Cross Blue Shield of Massachusetts is committed to advancing health care innovation in Massachusetts," said TemiTuoyo Louis, Director, Strategic Investments. "Partnerships with like-minded thought leaders like Healthbox help ensure that we are on the forefront of bringing ground-breaking ideas to life that have the potential of improving the health care eco-system."

TemiTuoyo Louis, Director of BCBSMA Strategic Investments and Nina Nashif, CEO of Healthbox, presented Christina Bognet and Judy Platt, Founders of Healthy Delivery, the 2012 Healthbox Innovator Award. Healthy Delivery offers an online, home-meal delivery service.

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In This Issue

Our Code of Ethics is Now Online

Blue Cross Blue Shield of Massachusetts and its Board of Directors, management, associates, and business partners are committed to doing business with honesty, integrity and respect for the law.

We created *The Blue Print*, a code of ethics and conduct for our employees, business partners, and providers. It serves as a guide to the laws and company policies that affect our business.

The Blue Print covers topics including:

- Conflicts of interest
- Records retention
- Reporting violations of policy or law.

To view *The Blue Print*, visit bluecrossma.com/provider and select Our Commitment to You.

While we are required to share this compliance information with providers who care for our Medicare Advantage members, we make it available to our entire network.

As a reminder, please report issues of non-compliance, fraud, waste, or abuse through our 24/7 anonymous hotlines. Compliance hotline: 1-800-554-6390; Fraud Hotline: 1-800-992-4100.❖

Office Staff Notes

AQC Year 3 Improves Affordability While Redefining the Provider Experience

Our Alternative Quality Contract (AQC) payment model continues to have a significant impact on efforts to increase both quality and affordability of health care in Massachusetts. A recent analysis by BCBSMA of year 3 of our AQC payment model indicates that we are on track to reach our goal of reducing annual health care cost growth trends by half over 5 years.

We have consistently heard from members of the health care community that the AQC's aligned quality and efficiency incentives foster more communication, coordination, and integration between primary care providers (PCPs) and specialists, and between physician groups and participating hospitals. The new environment created by this payment model seems to be increasing innovation and changing the way providers deliver care.

Improvements to quality

Preliminary analysis shows that AQC groups either maintained or improved their performance on patient experience and outcome measures.

- Groups that have been operating under AQC since 2009 continue to improve quality and outcomes—sometimes approaching "best achievable" performance.
- Groups that began using the AQC model in 2010 also continue to make strides, with specific success in chronic care management in 2011.
- Groups that began using the AQC in 2011 performed significantly better on ambulatory process measures compared to non-AQC providers.

Slowing the rate of spending

Our analysis shows the AQC is also significantly slowing the rate of increase in spending, compared to groups that do not participate in the AQC. That study revealed that participation in the contract over two years led to savings of 1.9% in year one and 3.3% in year two compared to non-participating groups. Groups that had no experience with risk-based contracts had even larger savings—6.3% in year one and 9.9% in year two. In 2011, savings were generated in two key areas:

- Lower utilization - AQC groups had fewer inpatient admissions, resulting in claim savings of over $10 million and more than $400,000 in avoided member cost-share. AQC groups also used fewer high-tech radiology services (MRI, CTs, nuclear medicine) than non-AQC groups, resulting in $3.3 million in avoided costs and over $300,000 in avoided member cost-share.
- Site of service changes - AQC groups started to move outpatient surgeries and procedures (such as colonoscopies) from hospitals to less-costly facilities, resulting in claim savings over the length of the contracts of an estimated $6.5 million.

Changing the Provider Experience

Anecdotal evidence shows that the global budget model facilitates sweeping changes in group culture, including changes in roles and responsibilities. According to interviews of physician leaders, PCPs, and specialists at all types of AQC groups, physicians are now working in teams with non-physicians (pharmacists, case managers, nurse practitioners, and diabetes educators, for example) who take on increased responsibility for patient contact and clinical decision-making.

Interviewees commonly cited several types of sustainable changes in the way groups and individuals practice:

- More attention is paid to quality indicators, transitions of care, preventable complications, and variations in practice related to overuse, underuse, or misuse of tests and procedures.
- Groups understand the value of dedicating resources to build new infrastructure and information systems; employ more nurses and medical assistants; offer patients extra preventive care, rehabilitation care, and consultation about medication use.
- Physicians spend more time trying to help patients get their care in the most appropriate setting, and explaining their recommendations to patients.

You can read more about specific ways groups are innovating at bluecrossma.com/aqc choose Provider Innovations in the Tools & Training tab.❖

Office Staff Notes

Use Clear Coverage to Enter Diagnoses for Molecular Diagnostic and Genetic Tests for HMO/POS Members

Technological advances are driving the rapid growth of new genetic tests and molecular diagnostic services. Appropriately used, these tests can help confirm a diagnosis, determine the risk of developing a disease or condition, offer insight on treatment options, and monitor response to certain pharmacogenetic agents.

Later this year, we will ask ordering providers and testing laboratories to use McKesson's online Clear Coverage application to supply us with data for genetic tests and molecular diagnostic services. This data will help us develop appropriate prior authorization requirements for these services. We have developed this approach after consulting with our network clinicians and laboratories.

The rapid growth in the number of genetic tests and molecular diagnostic services available can make it difficult for physicians to know which test is most appropriate for a patient. Health plans are also faced with the following additional challenges in making coverage decisions:

- Inadequate evidence-based guidelines.
- Lack of specific billing codes, resulting in use of CPT codes that do not provide information about the types of tests being performed and why.

Your participation will provide important information about the diagnosis for tests being ordered, and will help reduce the number of tests ultimately requiring utilization review.

Phased Approach Starts in Fall of 2013

Clinician Input Phase: Beginning this fall for HMO and POS members only, we will ask clinicians to enter the test name and diagnosis into McKesson's Clear Coverage web-based tool.

Medical Policy/Prior Authorization Phase: After we have analyzed the data, we'll work with clinical experts to determine which molecular diagnostic and genetic tests will require utilization review and prior authorization. You will receive advance notice about these requirements.

Instructions for Ordering Clinicians

During the Clinician Input phase, we will ask the ordering clinician to:

- Access Clear Coverage by logging on to bluecrossma.com/provider.
- Determine if your patient is included. We are only asking you to enter information about commercial HMO/POS members who live in and have a PCP based in Massachusetts. You only need to submit a notification when the member's information appears in the tool (PPO, Medicare HMO Blue® and Federal Employee Program members will not appear).

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The Importance of Continuity of Care

Communication between facilities, specialists, and PCPs is integral to facilitating safe, quality care, reducing medical errors and strengthening transition of care. We need your help to ensure this vital process continues and improves.

Until 2011, we evaluated communication systems by annually reviewing PCP office medical records, determined compliance with our medical record guidelines by examining operative notes, discharge summaries, and referral consult follow-up reports. These documents help the PCP stay fully engaged in all aspects of the patients' medical conditions. You can find more details about medical record guidelines in section 2 of the *Professional Blue Book*.

Important to transfer follow-up documentation

While NCQA no longer requires review of PCP medical record documentation, our final review found that PCPs often do not receive patient care-related documents from other facilities, providers and behavioral health providers.

We recommend your office review its processes to ensure that PCPs receive documentation about services their patients receive elsewhere in the health care system.

Enhancing communication between all providers is critical to addressing key quality issues, such as medical errors and readmissions.

Thank you for the care provided to your patients, our members.❖

Office Staff Notes

Mass Collaborative Focuses on Administrative Simplification Efforts

The Mass Collaborative*, a volunteer organization dedicated to reducing health care administrative complexities in Massachusetts, is working to improve a number of administrative processes. All are designed to increase transactional efficiency, eliminate waste, and promote standardization.

The Collaborative—formerly called the Massachusetts Healthcare Administrative Simplification Collaborative—was developed in 2009 to bring together health plans, providers and employers to address the most pressing administrative issues.

Efforts underway

After completing several initiatives, the Collaborative is now focused on the efforts listed below to simplify business interactions between payers and providers.

To improve:	The Collaborative is working to:
The eligibility process	Resolve gaps in federal operating rules
The provider licensing, privileging and credentialing processes	Reduce the length of time involved in these processes and reduce redundancies
The authorization process	Revise the current standardized authorization form to account for Chapter 224 legislative requirements
Communication of best practices	Identify and implement best practices in communication between providers and payers
Provider awareness of the Collaborative's efforts	Roll out a new website in 2013 (underway)

* Member organizations include:

- Blue Cross Blue Shield of Massachusetts and all other local health plans in state
- Several national health plans
- Massachusetts Hospital Association
- Massachusetts Medical Society
- Massachusetts Health Data Consortium
- Massachusetts Association of Health Plans
- MassHealth
- More than 25 individual provider organizations including Mass General, Partners Health Care, Atrius, Baystate, BIDMC.❖

An Easier Way to Submit Your Claims

Are you still submitting claims using InfoDial® or paper claim forms? We are pleased to offer a better alternative—Direct Data Entry (DDE), available through Online Services. This free tool is ideal for small and mid-size practices. Online Services can be used to submit any professional CMS-1500 claims when BCBSMA is the primary payer and no supplemental documentation is required.❖

To:	Please:
Learn more about DDE, view our online tutorial, or download our Quick Tips for registering and submitting claims	Log on to bluecrossma.com/provider and select the link in the "Direct Data Entry for Professional Claims" box on the right-hand side of the page.
Register for BlueLinks for Providers	Go to bluecrossma.com/provider and click on the blue box labeled Register Now.
Contact us with questions	Call 1-800-771-4097, option 4, M-F, 8 am-4 pm, or email us at provider.self.service@bcbsma.com.

Office Staff Notes

Focus on HEDIS: Initiation and Engagement of Treatment (IET) for Alcohol and Other Drug Dependence

The HEDIS IET measure tracks the percentage of members age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiation of AOD Treatment. The percentage of members who initiate treatment (have had a service with a claim) through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initial diagnosis.

	2012 IET HEDIS Scores	BCBSMA HMO/POS	90th Percentile	BCBSMA PPO	90th Percentile
Commercial	Initiation of Treatment	44.81%	48.66%	44.47%	46.90%
	Engagement of Treatment	16.57%	22.14%	16.81%	21.65%
Medicare Advantage	Initiation of Treatment	56.62%	58.54%	62.00%	58.97%
	Engagement of Treatment	5.88%	6.98%	8.67%	6.98%

Source: NCQA Quality Compass 2012

Opportunities to improve performance

As shown in the table above, less than half of our member population receives the recommended treatment for AOD. Both PCPs and behavioral health providers should code the diagnosis and follow-up visits appropriately to verify that the AOD diagnosis was addressed in each visit. The following scenarios illustrate gaps in care:

- Follow-up visits took place after the initial diagnosis, but did not include the alcohol and other drug diagnosis.
- Referrals were made, but the diagnosis was reported inconsistently by different physicians or other professional providers.
- Patients begin treatment, but fail to follow-up with subsequent treatment visits.

Addressing AOD in your patients

We suggest that PCPs use the Screening, Brief Intervention, Referral and Treatment (SBIRT) model, an evidence-based practice, to address AOD in your patients. The SBIRT model suggests that you to screen quickly to assess the severity of substance use and identify the appropriate level of treatment.
For a resource guide on screening, read the National Institute on Drug Abuse's *Screening for Drug Use in General Medical Settings* available on drugabuse.gov/publications/resource-guide.

Referring your patients for behavioral health services

After the initial diagnosis, consider referring your patient for behavioral health services if they:

- Demonstrate high-risk behavior
- Require medically supervised detoxification
- Have a history of substance abuse with other health complications.

For assistance finding a substance abuse provider or service for our members, please call 1-800-444-2426.

Three recommendations for high-quality care

1. Screen regularly for alcohol and substance abuse disorders.
2. Make sure all patients diagnosed have an initial substance abuse care visit within 14 days of the diagnosis.
3. Arrange two additional substance abuse treatment visits with yourself or another provider within the first 30 days from initial diagnosis. Report the AOD diagnosis in all follow-up visits. ❖

Ancillary News

Reminder: Sleep Management Program Kicks off July 1, 2013

Our Sleep Management Program will go into effect on July 1 and will be administered by AIM Specialty Health.

Ordering clinicians

Effective July 1, all clinicians who request prior authorizations for sleep studies or sleep durable medical equipment (DME) and supplies will need to be registered with AIM in order to request authorizations.

- If you are currently using AIM's website to request radiology authorizations, you do not need to re-register.
- If you are not currently using AIM's website, please register at aimspecialtyhealth.com/gowebsleep. You can start requesting authorizations for sleep studies or DME and supplies beginning June 16 for services on or after July 1.
- AIM can assist large group practices with the registration process.

June 1 deadline for facilities, sleep laboratories, and DME providers

Also as part of this program, facilities, sleep laboratories, and DME providers are required to complete an online assessment survey by June 1. Sleep providers that complete this assessment survey will be included in an online directory for referring providers. This requirement is not part of credentialing and does not affect network participation.

- To complete the assessment survey, go to aimspecialtyhealth.com/gowebsleep.
- If you have not registered previously with AIM, you will need to do so. After registering, complete the online survey assessment by selecting BCBS Massachusetts from the drop-down menu.
- You do not need to complete the assessment survey if you only read sleep testing results and do not perform the technical and/or global component of these services.❖

Attention SNFs: Incentive Program Submissions Due June 15th

The data collection period for this year's SNF Incentive Program closes on May 31, 2013. We suggest you use the templates located on our provider website to help you prepare your data for submission.

To access the templates or review the SNF Incentive Program details, log on to bluecrossma.com/provider and select the SNF Incentive Program 2013 link in the blue box on the right side of the home page.

Online reporting tools will be available on June 1, 2013. All submissions are due by June 15, 2013. To be eligible for this years' program, please remember these important program requirements:

1. The facility's representative who is authorized to submit the 2013 SNF Incentive data must be a registered BlueLinks for Providers user as of May 1, 2013.
2. Full completion of the Attestation form is required at the time of the data submission. If the form is submitted and not completely filled out, your facility will be fully disqualified from the program.❖

Healthbox Kicks Off Second Boston Accelerator Program This Month

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Last year's 10 health care start-ups developed innovative solutions addressing areas such as disease management, operational efficiency, and patient education.

This year's winning companies will participate in a large-scale Innovation Day, bringing together hundreds of investors, health care leaders, and entrepreneurs to hear the pitches of Healthbox companies in the context of industry need. We have given our AQC groups the opportunity to get involved by sponsoring, mentoring, hosting pilots, or participating in the curriculum as guest speakers.

For more details, visit healthbox.com.❖

Pharmacy Update

Requesting Prior Authorizations for Short-acting Opioids

Last July, we launched an opioid management program to reduce the risks of addiction and diversion of prescription opioid drugs while facilitating high-quality care for our members. As part of this program, a member can receive two short-acting opioid prescriptions (for up to a 15-day supply) within 60 days before prior authorization (PA) is required.

For an explanation of the PA process, please visit bluecrossma.com/medicalpolicies and search for our medical policy on opioids using either the policy number 102 or the key word Opioid.

To request authorization beyond the two 15-day prescriptions in 60 days, we recommend using the PA form at the end of policy 102. Please complete all fields; they include elements of evidence-based quality opioid prescribing that must be met, including:

- The existence of a treatment plan, including a clear diagnosis, explicit goals, and exploration of other treatment options.
- The use of informed consent and a formal assessment of addiction risk.
- The completion of a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances.
- A prescribing group and the use of one pharmacy or pharmacy chain by the patient have been agreed upon.

You do not need to request PAs for members with cancer, long term opioid use, and those who are at end of life.

We encourage you to use ExpressPAth, our web-based tool to submit opioid PA requests. Express PAth allows you to submit prior authorization and formulary

exception requests, quality care dosing overrides, and authorization renewals for commercial members 24 hours a day, 7 days a week. For information about how to register, submit requests, and check the status of your requests, please log on to bluecrossma.com/provider, click on Technology Tools, scroll down to ExpressPAth, and click on learn more.❖

Two Opioid and Pain Management Programs for Medicare Advantage Members

Inadequate pain management and prescription opioid addiction and abuse are growing public health issues. CMS has asked us to review opioid use among our Medicare Advantage members to help facilitate safe, appropriate use of these medications.

We have two programs to increase safety and reduce the risk of inadvertent addiction for our Medicare Advantage members:

- As of January 1, 2013, to increase safety around the use of drugs containing acetaminophen, we begin rejecting prescriptions for doses of 4 grams or more at the point of sale. The prescriber will need to give approval for these prescriptions to be dispensed.

- Starting April 1, 2013, we will identify Medicare Advantage members who are receiving potentially unsafe daily morphine equivalent doses (MED) across all targeted opioids (>120 mg/day for at least 90 consecutive days). We will contact the patient's prescriber to discuss the appropriateness and safety of the apparent high dosage for their patient and potentially refer the member to case management.❖

Pharmacy Update

Please Include Hemoglobin Levels on Red Blood Cell Agent Authorizations/Requests

We appreciate the work that clinicians are doing to improve the safety of patients being treated with red blood cell agents since we revised our medical policy for these medications in 2011 to include hemoglobin levels with all prior authorization requests.

This policy has improved care for our members. In 2012, only 12 members exceeded the recommended hemoglobin level of 12, compared to 157 members in 2009. Of these 12 members, nearly all had their dosage reduced after a consultation between their physician and the pharmacist—even the six members whose hemoglobin levels barely exceeded the recommended maximum.

When submitting prior authorization requests, please include the patient's hemoglobin levels; we occasionally receive authorization request forms without hemoglobin values. If your patient does not meet our medical policy requirements, please review the clinical guidelines to understand the importance of changing dosages when hemoglobin levels are above 12. To view our medical policy, log on to bluecrossma.com/provider and select Manage Your Business>Review Medical Policies and search for policy 262 or Erythropoietin.❖

Form Helps You Request Methadone Prior Authorization

We have updated our *Methadone Prior Authorization Request* form. Access the form by logging on to bluecrossma.com/provider and selecting Resource Center> Forms>Authorization Forms.

For information about our medical policies related to Methadone treatment, please refer to our *Medical Policy 274: Methadone Treatment: Intensive Detoxification or Ultra-rapid Detoxification for Opiate Addiction.*

Thank you in advance for your consideration in our efforts to ensure the highest quality of care for our members.❖

Medical Policy Updates

Lists of new, revised, and clarified medical policies are now available online. Log on to bluecrossma.com/provider, select Manage Your Business>Review Medical Policies>View Medical Policies. In the middle of the page, you will find summaries of Medical and Pharmacy Policy Updates, grouped by the month in which the policy or update is effective. Each month's list is organized alphabetically by policy title.

Click on the policy title to view a summary of the update.❖

Medicare Advantage

2013 Medicare Advantage Member Campaign Begins – Take Control of Your Health

In 2013 we continue to educate our Medicare Advantage members about the importance of playing an active role in their health care. We encourage our members to see their doctor regularly and to follow up, especially if they have chronic conditions.

Take Control of Your Health, our new campaign for Medicare Advantage members who are 65 and older, challenges them to be advocates for their own health. We have tested this message with a sample of Medicare members ages 65 and older and found that it resonates with them. The campaign's goal is to remind our members that they can positively influence their health by being engaged, informed, and prepared.

Promoting healthy aging

We often communicate to our Medicare Advantage members about steps they can take to promote healthy aging. This year, we will focus on encouraging members to either start or continue:

- Having a routine annual visit
- Discussing health concerns with their physician
- Following clinician advice, asking questions, and following up as indicated.

Preparing our members for appointments

Engaging your patients about issues of aging can be challenging, and older patients may hesitate to bring up important topics. In this year's campaign, we will urge our members to discuss these topics with you at their next appointment:

- Improving bladder control
- Improving or maintaining physical and mental health
- Monitoring physical activity
- Reducing the risk of falling.

We will also emphasize the importance of being prepared to talk to you about their current medications, recent health concerns, and other questions about aging.

To learn more about the conversations we're having with our members, visit bluecrossma.com/GetActive.❖

Send us your ideas

What would you like to see our Medicare Advantage members do to take control of their health? Perhaps it's something they should prepare in advance of a routine visit, or something they should do between visits. E-mail your suggestions to focus@bcbsma.com.

Use Clear Coverage for Molecular Diagnostic and Genetic Tests

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Instructions for Ordering Clinicians (continued)

- Use Clear Coverage to select the diagnosis, test, and your identifying information. You may choose to review the test-specific, evidence-based support tools, and BCBSMA policy information that Clear Coverage offers and print a laboratory notification for your patient.

Instructions for Servicing Laboratories

We will ask servicing laboratories to check whether the ordering provider has entered the diagnosis, test ordered, and ordering provider information into Clear Coverage for HMO/POS members who live in and have a PCP based in Massachusetts. If you:

- Do not see the member's information in Clear Coverage, no further action is required.
- Do see the member's information but the ordering clinician has not entered the diagnosis and procedure code, we ask that you either enter it or call the physician's office to ask them to enter it

We will hold trainings before this program goes into effect

Before we ask you to particiapte in this program, we will hold trainings to help you and your staff learn to use the Clear Coverage tools and develop efficient workflows. We will send you more details about these opportunities and the program launch date as they become available.❖

Coding Corner

This section offers tips on how to code services for complex cases and how to complete your CMS-1500 claims accurately to help ensure prompt payment.

Coding "Rule-Out" or Uncertain Diagnoses: Inpatient Versus Outpatient Settings

Properly coding services for patients whom you are evaluating for possible conditions helps accurately reflect the patient's health status and medical record documentation and this will help to avoid inappropriate identification of patients for care management services. The following guidelines may be helpful:

If the setting is:	Then an uncertain diagnosis:
Inpatient admissions to acute, long-term care, or psychiatric hospitals	Should be included on the claim using the suspected diagnosis code.
Outpatient care	Should NOT include a code for the suspected diagnosis. Until a diagnosis is confirmed, include codes only to the highest degree of certainty for that encounter/visit, such as the *signs or symptoms, abnormal test results, or other reason for the visit.*

Example

An older adult patient has an office visit and complains of joint pain in the hands. The patient is then evaluated for both osteoarthritis and rheumatoid arthritis concurrently. If, at the end of the office visit, no diagnosis has been made, the claim for the office visit should not include the uncertain diagnoses of osteoarthritis (715.14) or rheumatoid arthritis (714.0). Instead, code only to the highest degree of certainty for that visit, which in this example includes the symptom of joint pain in the hand (719.44).

Payment Policy Update

Effective July 1, 2013, BCBSMA will implement the following new or revised payment policies:

- We will no longer reimburse for the professional component (modifier 26) of a radiology procedure when performed with an Evaluation and Management (E&M) service in an office setting by the same provider, on the same day. The professional component will be considered incidental to the E&M service.
- Payment for Medicare Advantage services submitted with a Modifier 52 will be decreased by 50%.
- We will limit coverage of compression stockings to those with 30 mm Hg pressure or greater. Members will also be limited to two (2) pairs of compression stockings every 6 months.
- BCBSMA will implement CMS modifier logic, found in the CCI Column 1, Column 2 documents. Code combinations that are identified as mutually exclusive or incidental will no longer be allowed to pay with a modifier if they are designated with an indicator of "0". CMS/CCI data can be found at: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html. Services that are supported by clinical documentation as separately identifiable can be appealed using the standard Individual Consideration process.❖

BlueLinks Account Spring Cleaning

Please keep your BlueLinks account information up-to-date so you receive important updates from us. This is required by the terms of use you agreed to when you registered.

If you are a:	Please:	By logging on to bluecrossma.com/provider and selecting:
Registered user	Update or verify your email address	Manage My Profile>Edit My Profile.
Administrative user*	■ Delete users no longer working in your office	Manage My Profile>Manage Users. Select checkbox for users no longer working in your office, then click "Remove Selected" button.
	■ Delete pending users who have been on your list for more than 30 days	Manage My Profile>Manage Users. Select checkbox for pending users (listed as pending in User Name column), click "Remove Selected" button. Be sure to review all pages of listed users.

**To verify that you are an administrative user, log on to bluecrossma.com/provider. Under Manage My Profile, look for the Administration header.*❖

Our Member Rights and Responsibilities Statement Is Available Online

A copy of our "Member Rights and Responsibilities" statement is available in the Member Education section of your *Blue Book* manual on our website.

To view this information, log on to bluecrossma.com/provider and click Resource Center>Admin Guidelines & Info>Blue Books. Under the Professional *Blue Book* listing, click on Appendix then select Member Education.

The Rights and Responsibilities section appears on pages 7-12.❖

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