Blue FOCUS

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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

WINTER 2011

Updates to Tiered Network and Hospital Choice Cost-Sharing Status

Blue Cross Blue Shield of Massachusetts (BCBSMA) will be making several updates to our Tiered Network and Hospital Choice Cost-Sharing benefit. These changes will be effective in a one-day change on January 1, 2012 for all existing customers and for new sales of these plans.

Hospitals Changing Due to Improvements in Cost

Based on significant improvements in certain hospitals' cost data, BCBSMA will adjust the way those hospitals are designated in our Blue Options tiered network family of plan designs and plans that include the Hospital Choice Cost-Sharing benefit feature.

The following hospitals have experienced improvements in cost, and we are therefore changing their status from Basic to Standard tier: St. Anne's and Cooley Dickinson. Please note that when you refer members of our tiered network family of plans and those with the Hospital Choice Cost-Sharing benefit feature to these facilities, they will have lower cost-sharing when receiving care from these facilities starting January 1, 2012.

Specialty Hospitals Changing Due to Evaluation on Quality Metrics

In addition, we previously considered specialty hospitals to have insufficient data for purposes of defining an overall quality score for tiering. To let members select

low-cost, high-quality specialty hospitals for their care, speciality hospitals designated as lowest-cost were allowed to submit quality metrics for evaluation. Massachusetts Eye and Ear Infirmary and New England Baptist Hospital were eligible to submit quality data, which was reviewed against BCBSMA quality measurement criteria.

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In This Issue

ICD-10 Information Available via BlueLinks for Providers

BCBSMA is assessing the impact of the ICD-10 mandate and preparing for the October 1, 2013 implementation. We are working collaboratively with the Massachusetts Health Data Consortium (MHDC), Massachusetts Medical Society (MMS), Massachusetts Hospital Association (MHA), and the Massachusetts Association of Health Plans (MAHP) to ensure statewide readiness for the mandate.

For information on BCBSMA readiness, including *FAQs* and links to helpful websites, log on to bluecrossma.com/provider and click on the ICD-10 link.

We will provide more information and resources online and in *Provider Focus* as the implementation date nears.❖

Pharmacy Update

New Maintenance Medication Benefit Offers Convenience and Lower Cost

As we previously announced in a September *F.Y.I.*, we are adding the Exclusive Home Delivery feature as a standard benefit for many HMO Blue products (HMO Blue New England is excluded) starting on January 1, 2012 and upon anniversary.

Members with this benefit feature are *required* to use a designated Mail Service Pharmacy for a specific list of maintenance medications used to treat chronic conditions such as asthma, diabetes, coronary artery disease, and for birth control and antiviral medications. This helps us control costs for these medications and offers our members greater convenience. In addition, and studies suggest that patients are more likely to adhere to their prescribed treatment regimen when medications are filled through mail order.

Because of this new feature, you may experience an increase in members requesting 90-day prescriptions (for Mail Service) for their maintenance medications.

New Prescriptions

We recognize that many members who are newly prescribed a medication may often need to have adjustments made to the medication or dosage by their treating clinician.

That's why members are encouraged to have their first two prescriptions filled at a retail pharmacy before they are required to use a designated Mail Service Pharmacy.

This also helps to avoid any medication waste and gives you the ability to prescribe a 30-day supply before the member transitions to 90-days.

To learn more about Exclusive Home Delivery, get answers to frequently asked questions, and review the list of maintenance medications and where they can be filled, please log on to bluecrossma.com/provider and click on Manage Your Business> Search Pharmacy & Info> Exclusive Home Delivery.❖

Reminder: Walgreens to Terminate Its Agreement with Express Scripts, Inc.

In the fall issue of *Blue Focus*, we reported that Walgreens would no longer be participating in the Express Scripts, Inc. (ESI) retail pharmacy network as of January 1, 2012.

This means our members will need to transition retail prescriptions for medications—including specialty medications—to a new pharmacy.

Therefore, you may receive requests for a new prescription from your patients who use Walgreens.

For more details and late-breaking news if an agreement is reached between the two parties, log on to our website at bluecrossma.com/provider and click on the Walgreens Termination with ESI link.❖

BCBSMA News

BCBSMA Is Ready to Assist Members and Providers During a Disaster

BCBSMA has undergone extensive planning and preparation to ensure we are able to support our customers in the event of a disaster or emergency.

If we are faced with this kind of an unfortunate event, our company is prepared to focus on six priorities:

- Ensuring the safety and well-being of our employees
- Enabling continued access to care for our members
- Maintaining financial stability in order to continue to support care provided to our members
- Providing our members and providers with information
- Recovering and normalizing business operations
- Supporting community-based response and recovery efforts.

These efforts are already having a positive impact on our members and providers.

For example, our mobile workforce enables a significant number of our employees to work remotely.

During past winters, this capability has allowed BCBSMA to serve our customers through snow emergencies when many other businesses were forced to close.

You can read more on our disaster readiness efforts online. Go to bluecrossma.com/visitor; under the "About Us" menu, choose Disaster Readiness.❖

Updates to Tiered Network and Hospital Choice Cost-Sharing Status

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As a result of the review, both organizations will be listed as having met our benchmarks for quality data and will move from our Standard to our Enhanced Benefits Tier for all existing customers and new sales, effective in a one-day change on January 1, 2012.

About Our Options Family of Tiered Network Plan Designs and Hospital Choice Cost-Sharing Benefit Design

For members of our tiered network plans, the member's share of the cost for care from a hospital or PCP is based on the tier of the provider rendering the services. This encourages members to consider the cost and quality of the provider they are selecting each time they seek care and to speak with their PCP about this when they are being referred for a service. Additionally, it rewards them for choosing providers in best-performing tiers.

For members with our Hospital Choice Cost-Sharing feature, members have higher cost-sharing for inpatient and outpatient services at those hospitals that are in the Basic Benefits Tier of our Blue Options tiered network plan.

Because we plan to update PCP tiers regularly, we encourage your practice to continue your existing quality and cost-improvement activities.

As always, we encourage you to check member eligibility and benefits using one of our electronic technologies prior to rendering services.❖

Medicare News

BCBSMA Announces Medicare Product and Benefit Changes for 2012

To ensure we continue to provide a full array of Medicare solutions to our members, effective January 1, 2012, BCBSMA will offer a new low-cost, direct-pay Medicare Advantage health plan to members. We will also modify pharmacy plans and Part D coverage for our existing Medicare Advantage products (Medicare HMO Blue℠ and Medicare PPO Blue℠, Blue MedicareRx). To reflect the changes, we are issuing new I.D. cards to these members.

Below we provide a high-level description of these changes.

As always, please check each patient's eligibility and applicable benefits before delivering services to ensure the member has coverage for the services you are providing and that you are collecting the appropriate cost-share from them.

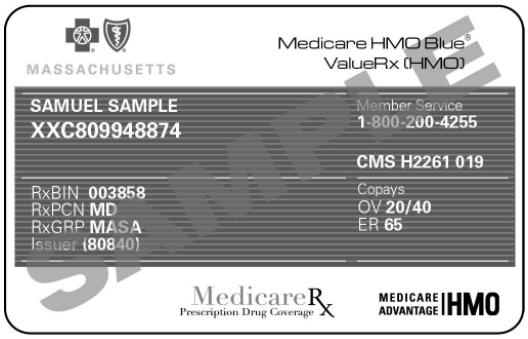
New Plans, Benefits Available in 2012

Prospective members may choose Medicare HMO Blue Value Rx, a new low-cost managed care option with Medicare Part D prescription coverage with a $1,000 medical plan deductible, and tiered plan prescription drug coverage options. *(See sample ID card.)*

Pending approval from the Division of Insurance, we will offer Dental Blue 65 Preventive, a new direct-pay dental plan available for Massachusetts residents aged 65 and over beginning January 1, 2012. This plan provides services to diagnose or prevent tooth decay and other forms of oral disease.

New Fitness, Weight Loss and Foreign Travel Benefits for Direct-pay Medex. Effective January 1, 2012, all Medex Bronze and Medex Core members will be entitled to a fitness benefit and weight loss benefit of $150 each per year. Medex Core members will also be entitled to receive health care benefits for services outside of the United States—currently Medex Bronze is the only open Medex plan that carries this benefit.

Sample ID card for the new Medicare HMO Blue Value Rx plan



Changes to Medicare HMO Blue℠, Medicare PPO Blue℠

We are making a number of changes to copayments for Medicare-covered chiropractic services, routine vision care, emergency care, and more, effective January 1, 2012.

For instance, Medicare HMO Blue members will pay nothing for Medicare-covered standard eyeglasses or contact lenses when prescribed and filled by a Davis Vision provider.

In addition, we will no longer cover nutrition counseling not covered by Medicare.

Medicare Formulary Changes

Changes will be made to our Medicare Advantage and Blue Medicare Rx Prescription Drug Plan formularies, effective January 1, 2012. *(See pharmacy article in the fall 2011 issue of Blue Focus.)*

For More Information

For more details on these 2012 product and benefit changes, go to www.bluecrossma.com/provider and click on Health and Dental Plans; then scroll down and click on the Medicare 2012 Product Changes link.❖

Office Staff Notes

2012 Product and Benefit Changes: More Affordable Options for Members

As part of our ongoing commitment to employers and members to offer high-quality, affordable health care products, we will be making several product and benefit enhancements on January 1, 2012.

We urge you to check member eligibility and applicable benefits before delivering services to ensure the member has coverage for the services you are providing and that you are collecting the appropriate cost-share from the member.

Blue Options Tiered Network

Starting January 1, 2012, we will offer a new, lower-cost tiered network plan design variation: HMO Blue New England Options℠ Deductible II V.3. This new variation mirrors the existing HMO Blue New England Options Deductible V.3, but applies a different level of member cost-sharing for the emergency department, inpatient, outpatient day surgery, PCP office, high-tech radiology, and prescription drug benefit categories.

Value-Based Benefits

To help members with certain chronic conditions better afford and manage their care, we will add value-based benefits to most of our HMO Blue New England and PPO plans for groups with fewer than 100 enrolled employees. When these members use the mail service pharmacy, they will pay less for certain maintenance medications used to treat asthma, diabetes, coronary artery disease or risk for cardiovascular disease (taking high blood pressure medications in conjunction with high cholesterol medications), and depression (when associated with asthma, cardiovascular disease risk, or diabetes). Also, there will be no cost for two diabetic monitoring visits per year and no cost for Tier 1 and Tier 2 tobacco-cessation medications (indicated when you check benefits and eligibility using our technologies).

NEW PLAN: HMO Blue New England $2,000 Deductible

This plan design for individuals and small group accounts has a $2,000 individual/$4,000 family deductible, and includes Hospital Choice Cost-Sharing as a standard benefit feature.

Durable Medical Equipment and Prosthetics

Starting on January 1, 2012 and upon account anniversary, we will:

- Eliminate existing calendar-year dollar limit maximums for DME
- Add or change the member's cost-share for DME and/or prosthetic benefits. For example, if the plan has no cost-share for DME or prosthetics today, it will now have a 20% co-insurance for these benefits.

The changes are based on plan design; we'll provide more details on cost-share changes for specific DME services later this fall.

Short-Term Rehabilitation Therapy

To encourage treatment adherence and improved outcomes, we will change the short-term rehabilitation therapy benefit cost-share for our HMO Blue New England Options Deductible plan design (currently $50 per visit). Effective on account anniversary date starting on or after January 1, 2012, the short-term rehabilitation therapy cost-share will be $25 for visits 1-20 and $50 for visits 21-60 across all three benefit tiers: Enhanced, Standard, and Basic.

Product Portfolio Updates

For consistency across our products, certain plans will change to include: applying the outpatient medical visit cost-share for outpatient surgery performed in the office, hospital, or other day surgical facility; changing the out-of-pocket maximum calculation to include inpatient admissions; and applying the outpatient medical care or outpatient mental health office visit cost share for medical and mental health care services delivered in the home.

Outpatient Medical Care/Mental Health Visits in a Home Setting

As noted above, BCBSMA will be applying the outpatient medical care office visit cost share to:

- Outpatient medical care and mental health visits rendered in a home setting for certain standard managed care plans
- Outpatient mental health visits rendered in a home setting for certain standard New England managed care plans.❖

Office Staff Notes

BCBSMA to Reimburse Subscribers Directly for Services Rendered by Non-Participating Facilities, Effective January 16, 2012

Last year, BCBSMA changed the way we reimburse non-participating physicians and clinicians. In November 2010, we began to reimburse subscribers directly for certain services rendered by non-participating, out-of-network providers.

Non-participating providers are defined as those who do not participate in a member's product.

Now, in a continued effort to deliver more affordable products to our accounts and members, we are expanding this subscriber payment policy to include facilities.

Effective for dates of service on or after January 16, 2012, BCBSMA will reimburse subscribers directly when they receive services from a facility that does not participate in the member's product.

This will affect claims with dates of service on or after January 16, 2012.

For example, if the member belongs to a PPO product and the facility does not have a PPO Agreement, the member will be reimbursed directly for services received there.

This change applies to all products and services except:

- Indemnity
- HMO Blue® New England, Blue Choice® New England, and Access Blue® New England members with a primary care provider (PCP) outside of MA
- Medicare products and Medicaid
- Federal Employee Program
- BlueCard® program claims originating from states other than Massachusetts
- Dental services
- Veteran's Administration services.

Important Note: in the November 2011 *F.Y.I.* that we mailed to facilities about this reimbursement change, we inadvertently omitted the Federal Employee Program (FEP) from this list of exceptions. Therefore, we'd like to clarify that FEP members are excluded from this reimbursement change.❖

Questions?

If you have any questions, or would like to discuss becoming a participating provider with BCBSMA, please call Network Management Services at 1-800-316-BLUE (2583).❖

Blue Choice Plans 1 and 2 Will Be Included in the Pay-Subscriber Policy

Effective January 16, 2012, we will begin to pay subscribers who belong to our Blue Choice® Plan 1 and Blue Choice® Plan 2 products for services they receive from any provider who does not participate in their product, including both professional and facility providers.

Previously, Blue Choice Plans 1 and 2 were excluded from the pay-subscriber policy.

This reimbursement change is designed to encourage providers to participate in all of our networks and to ensure that our members are being treated by contracted, in-network providers so we can better manage our members' health care, costs, and quality.❖

Office Staff Notes

BCBSMA's Claims Processing System Will Be Updated in 2012 and 2013

BCBSMA will begin upgrading our claims system to the NASCO platform throughout 2012 and 2013. NASCO is a system shared by BCBSMA and other Blue Cross Blue Shield plans nationwide. This enhancement will help us process claims more efficiently, and will ensure we are fully compliant with ICD-10, which goes into effect October 1, 2013.

BCBSMA has partnered with NASCO for health care claims processing services since 1992 and currently uses the NASCO platform to process 25% of claims.

What You Can Expect

You can expect very little impact, but as our membership migrates onto the new platform in waves, you will notice a gradual shift in the advisories that you receive. For claims processed through NASCO, you will receive Provider Vouchers in place of the current Provider Payment Advisories (PPAs) and Provider Detail Advisories (PDAs).

As the system upgrade progresses throughout 2012 and more claims are processed through NASCO, the number of vouchers you receive will increase, while the the number of PPAs and PDAs will decrease. In addition, approximately 70,000 members will receive updated ID cards with a new the alpha-prefix.

We will keep you posted on the progress of this upgrade in future issues of *Blue Focus*. If you have any questions, please call Network Management Services at 1-800-316-BLUE (2583).

About Electronic Fund Transfer (EFT) and Direct Deposit

If you are registered through PaySpan Health to receive direct deposit, you do not need to do anything to add EFT functionality for NASCO or to receive remittance advices through online display. You will receive payment and online display functionality automatically.

If you are not registered, we encourage you to do so today. Log on to bluecrossma.com/provider and click on Technology Tools>Go to PaySpan Health.

With PaySpan Health, you'll receive expedited electronic payments and online remittance advices for all BCBSMA NASCO payments.❖

HIPAA Version 5010 Will Be Implemented January 1, 2012: Are You Ready?

In anticipation of the implementation of HIPAA version 5010, please check with your vendor or IT staff on their 5010 preparation status.

If you are a direct submitter and you have not yet set up a time to test with BCBSMA, please send an e-mail as soon as possible to EDIsupport@bcbsma.com.

BCBSMA continues to conduct external testing. To meet the implementation date of January 1, 2012, all testing must be completed by December 31, 2011.

All entities conducting electronic claim submissions, claim status requests and responses, referral/ authorization requests and responses, eligibility/ benefit requests and responses, and claim remittances will be required to use Version 5010.

Questions?

To assist you, please refer to our *Frequently Asked Questions*, available at bluecrossma.com/provider. From the home page, click on Manage Your Business, then scroll down to the HIPAA Version 5010 section and click on the link.❖

Office Staff Notes

Important Update: Use of Modifiers on UB-04 Claims

In compliance with Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Health Care*, BCBSMA currently accepts modifiers on UB-04 claims, and we continue to enhance our system to ensure that all modifiers can be read in any of the first three fields of the claim. We expect the system changes to be fully implemented by early first quarter of 2012.

As a reminder, UB-04 claims submitted for bilateral services should be billed using the industry standard methodology—placing the service on one line with modifier 50; reimbursement will be 150% of the contracted fee schedule amount.

In addition, please note the following regarding diagnosis codes:

- When submitting claims for reimbursement, be sure to report all services using the most up-to-date industry standard procedure, revenue, and diagnosis codes, including modifiers, when applicable.
- When billing services for which BCBSMA has a medical policy, our system has the capability to read all diagnosis codes included on the claim.❖

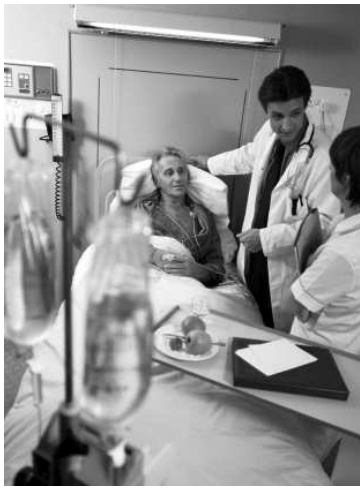
Outpatient Fee Schedule Updates for Long-Term Care, Chronic, and Rehab Hospitals

Effective for dates of service on or after January 1, 2012, BCBSMA has updated its outpatient fee schedules to include new 2012 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes for all products covered under your Agreement.

We have also deleted those codes no longer valid under the 2012 CPT/HCPCS coding structure.

To access a summary of the coding changes online:

- Log on to our website at www.bluecrossma.com/provider.
- Click on to News for You> FYIs, then select the *F.Y.I.* titled *Additions, Deletions to Your 2012 OPD Fee Schedule* (PC-1479C). The coding changes appear in a PDF document called *2012 CPT/HCPCS Coding Changes.*



Complete electronic versions of your hospital outpatient fee schedules will be available through your Network Manager at the end of January 2012.

If you have any questions, you can reach your Network Manager at 1-800-316-BLUE (2583).❖

Reminder: "Record a Visit" Function Eliminated

As a reminder, we have eliminated the Record a Patient Visit function from Emdeon Office, InfoDial®, and the Point of Service device.

Instead, you can use the following functions, which are also available through the same technologies:

- Eligibility Request: Use to check eligibility
- Service Review Inquiry: Use to check for the presence of a referral, outpatient authorization, or inpatient authorization.

If you have any questions, please call Network Management Services at 1-800-316-BLUE (2583) ❖

Office Staff Notes

Reminder About BCBSMA's Standards in Utilization Management

As stated in section 2 of your *Blue Book* manual, it is our position that decisions regarding health services should be made solely on the appropriateness of care and the existence of coverage.

Any health care provider who delivers services to our members must also ensure that the care is both effective and efficient.

BCBSMA believes that our members are best served when their care is well-coordinated and appropriate for their needs. Care decisions should be based only on whether they are appropriate for the member and are consistent with evidence-based, high-quality, cost-effective care.

As a matter of policy, we do not provide financial incentives that encourage practitioners to deny medically necessary, appropriate health care services.

While over-utilization of health care services can be harmful, costly, or inconvenient to members' health, under-utilization is a special concern as well.

Adverse outcomes that can result from under-utilization, include:

- Missed opportunities to prevent illness
- Missed opportunities to diagnose and treat illness at an early stage, which can lead to significant complications
- Inadequate treatment resources for chronic illness, which can contribute to poor outcomes and higher costs.

To access your *Blue Book*, log on to bluecrossma.com/provider and click on Resource Center> Admin Guidelines & Info> Blue Books.❖

What Administrative Technologies Do You Use? Complete HCAS' Survey

The Massachusetts Division of Healthcare Finance and Policy (DHCFP) requires health plans to submit technology adoption data from their network providers in an effort to increase transparency, quality, and efficiency in the health care delivery system.

To assist health plans with this requirement and to help streamline the process, Healthcare Administrative Solutions (HCAS) will collect provider technology information on behalf of eight participating health plans.

These participating health plans are: BCBSMA, Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Network Health, and Tufts Health Plan.

Your participation will help these health plans and DHCFP better assess technology use. The survey takes only a few minutes to complete, and the information provided will be submitted to DHCFP and the participating health plans.

To access the survey in early January and to learn more, go to hcasma.org.❖

Ancillary News

Update on 2012 CPT®´/HCPCS Codes for Ancillary and Behavioral Health Providers

We are currently reviewing the new CPT and HCPCS codes released for dates of service starting on January 1, 2012 to make any applicable fee schedule changes. As a reminder:

Do not bill for deleted codes after January 1, 2012.

Ancillary and behavioral health providers: bill only for codes that are on your current Agreement. We provide reimbursement only for codes included on your Agreement.

We plan to post changes (including any additions, deletions, and narrative changes) and a revised fee schedule online in the first quarter of 2012.

In addition, we will only communicate these updates via our BlueLinks for Providers website and will not mail a printed *F.Y.I.* notice. Therefore, if you have not already done so, we urge you to register for updates via e-mail.

Registering for eNews Alerts

To register to receive news and updates via e-mail, please follow these instructions:

Log on to bluecrossma.com/provider

Click on Edit My eNews Subscriptions (listed under Manage My Profile on the left-hand side of your screen).

Select the types of communications for which you want notification. (Be sure to select General News & Updates to receive news about CPT/HCPCS code changes that impact your provider specialty.)

Click on Save.

Questions?

If you have questions, please call Network Management Services at 1-800-316-2583 (BLUE).❖

Medical Policy Update

Changes to Medical Policy 400, *Medical Technology Assessment Non-Covered Services*

Effective January 1, 2012, medical policy 400, *Medical Technology Assessment Non-Covered Services* now includes entries only for non-covered services that do not have an associated BCBSMA medical policy. The most accurate way of determining whether a service is non-covered is to perform a keyword search on our Medical Policy page online.

Simply go to bluecrossma.com/provider and click on Medical Policies in the blue box. Then, enter a keyword in the Quick Search box at the top right-hand corner of the screen and click on Go.

If you have any questions about this change, please send an e-mail to ebr@bcbsma.com.❖

Minimally Invasive Procedures Coverage

Effective February 1, 2012, minimally invasive procedures that do not have specific procedure codes are covered if the conventional procedure is covered. In addition, they are reimbursed at the same rate as the conventional procedures. The Payment Policy will be posted on our website on February 1, 2012.❖

New Non-covered CPT and HCPCS Level II Codes

We have updated medical policy 400, *Medical Technology Assessment Non-Covered Services*, to include the new CPT and HCPCS Level II codes. These codes, effective January 1, 2012, have been identified as non-covered.❖

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Medical Policy Update

All updated medical policies will be available online. Go to www.bluecrossma.com/provider>Medical Policies.

Changes

Computer-Assisted Corneal Topography, 301. Adding coverage for this procedure. Effective 3/1/12.

Medical Technology Assessment Non-Covered Services, 400. Adding coverage for CPT code 90654 (Influenza virus vaccine, split virus, preservative free, for intradermal use). Effective 8/1/11.

Sleep Disorders Diagnosis and Treatment: Supervised Polysomnography; Unattended Home Sleep; Studies; Multiple Sleep Latency Testing; Continuous Positive Airway Pressure (CPAP); Bi-level Positive Airway Pressure (BiPAP); Auto-adjusting CPAP; Oral Appliances, 293.

Removing references to respiratory disturbance index (RDI). Effective 2/1/12

Revising criteria for oral appliances. Effective 2/1/12.

Clarifications

Catheter Ablation of the Pulmonary Veins as Treatment for Atrial Fibrillation, 141. Edited policy statements for clarity, but no change was made in intent of policy statements. Information about repeat procedures reinserted into policy.

Hematopoietic Stem Cell Transplantation for Multiple Myeloma, 075. Added the phrase "in the tandem sequence" to the medically necessary tandem autologous-autologous statement.

Medical Technology Assessment Non-Covered Services, 400. Clarifying non-coverage of Solesta®˝ for the treatment of fecal incontinence.

New Medical Policies

The following is a list of new medical policies describing ongoing non-coverage. These procedures were previously addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*:

Acoustic Cardiography, 537.

Baroreflex Stimulation Devices, 595

Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure, 594.

DNA-Based Testing for Adolescent Idiopathic Scoliosis, 545.

Intracavitary Balloon Catheter Brain Brachytherapy for Malignant Gliomas or Metastasis to the Brain, 602.

Interspinous Distraction Devices (Spacers), 584.

Low-Level Laser Therapy, 522.

Lysis of Epidural Adhesions, 598.

Plugs for Fistula Repair, 528.

Skin Contact Monochromatic Infrared Energy as a Technique to Treat Cutaneous Ulcers, Diabetic Neuropathy, and Miscellaneous Musculoskeletal Conditions, 507.

Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea, 570.

Surgical Ventricular Restoration, 544.

Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress Incontinence, 523.

Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis, 547.

Whole Body Dual X-ray Absorptiometry (DEXA) to Determine Body Composition, 577.❖

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Go to www.bluecrossma.com/provider and click on Register Now in the blue box.

At Your Service

Hospital providers:

- For claims-related questions, call Provider Services at 1-800-451-8123 (hours: M - W, F: 8:30 a.m. to 4:30 p.m., Th: 9:30 a.m. to 4:30 p.m.)
- For all other questions, call your Provider Relations Manager at 1-800-316-BLUE (2583).

Ancillary providers:

- For claims-related benefit and eligibility questions, call Ancillary Provider Services at 1-800-451-8124 (hours: M - W, F: 8:30 a.m. to 4:30 p.m., Th: 9:30 a.m. to 4:30 p.m.)
- For all other questions, call your Ancillary Provider Relations Representative at 1-800-316-BLUE (2583), Option 2.

Fraud Hotline: 1-800-992-4100
Please call our confidential hotline if you suspect fraudulent billing or health care activities.

All providers:

- To access BCBSMA's medical policies and administrative tools, go to www.bluecrossma.com/provider and click on Medical Policies. Or, call Fax-on-Demand at 1-888-633-7654. Request document 411 for a list of all available documents.

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