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 2013

Improving Cost and Quality Transparency in Health Care for Members and Providers

Just as the Internet has altered the way consumers make decisions in other areas of their lives, it has the potential to provide patients with meaningful quality and cost data about health care providers and services.

We want members to have more information so they can work with their doctor to select the right care for them and minimize their out-of-pocket costs. These efforts to make health care information more transparent also support our providers in the Alternative Quality Contract (AQC), which provides incentives when providers and members together make the best use of health care resources.

Member transparency efforts

We'll update our online Find a Doctor tool this winter to offer members improved tools, including the following:

- An all-new design and user interface to improve the user experience.
- The ability to search for a Blue Distinction Center-designated facility. Blue Distinction is the Blue Cross Blue Shield Association's (BCBSA's) national program that recognizes facilities providing high-quality, cost-effective care in Spine Surgery, Knee and Hip Replacement, Cardiac Care, Transplants, Complex and Rare Cancer, and Bariatric Surgery.

- A notation for physician practices that have received BCBSA's Blue Physician Recognition. It denotes physician practices that have accepted accountability for quality, value, and outcomes; AQC-contracted practices will have this recognition.

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In This Issue

We're Ready to Assist You and Members During a Disaster

We continually prepare for disasters and emergencies. If an unfortunate event occurs locally, our company will focus on:

- Ensuring our employees' safety
- Enabling continued access to care for our members
- Continuing to pay provider claims
- Keeping members and providers informed
- Recovering and normalizing business operations
- Supporting community-based response and recovery efforts.

With a significant number of employees working remotely, we have been able to serve our customers through snow emergencies when other businesses were forced to close. To learn more, go to **bluecrossma.com/visitor,** click on **About Us>Disaster Readiness.**❖

Quality News

Our Quality and Performance Improvement Initiatives

We design our quality initiatives and performance improvement programs to support physician-patient relationships, promote patient safety, and educate members on effective self-management. These programs are described in our newly updated *Quality and Performance Improvement Initiatives* brochure.

This year, we've added information about our Alternative Quality Contract, CMS 5-Star efforts, and chronic condition management programs as well as the quality and cost transparency tools that help engage members in health care decisions.

To read the updated brochure, log on to **bluecrossma.com/provider,** then click on the **Welcome New Providers** link on the home page and scroll to the **Quality and Performance Improvement Initiatives brochure**. Or, call Network Management and Credentialing Services at **1-800-316-BLUE (2583)** for a copy.❖

CMS 2013 5-Star Quality Rating Scores Released

Thanks to the quality care you provide to our members, our Medicare Advantage HMO and PPO plans earned 4.5 stars through the 2013 CMS 5-star rating system—an increase for our HMO plan score of 4.0 last year.

CMS ranks health plans on a scale of 1 to 5 stars to drive improvement in health care for Medicare Advantage beneficiaries; a 5-star score represents the highest quality.

Learn more about the CMS rating system

To learn more about the rating system, view a complete table of our performance scores, and access tools and resources to assist you with the measures, log on to **bluecrossma.com/provider** and select **CMS Medicare Quality Ratings** in the blue box on the right side of the home page.❖

Office Staff Notes

Updated Forms Have Been Posted on BlueLinks for Providers

We have updated the following authorization and services extension request forms to include additional fields for provider NPIs:

- *Inpatient Hospice Clinical Review Form*
- *Medical Nutrition Therapy Authorization Extension Request Form*
- *Initial Precertification Form for SNF/Rehab/LTCH*
- *SNF/Rehab/LTCH Clinical Recertification Form*
- *Behavioral Health Out-of-Network Request Form*
- *Pre-Authorization for Non-Emergent Ground Ambulance Transport.*

The additional NPIs requested on the forms help us process requests efficiently and accurately.

To download or print the new versions, log on to our website at **bluecrossma.com/provider** and click on **Resource Center> Forms.**❖

Office Staff Notes

Our Revised Tiered Network Plan—Blue Option V.4—is Now Available

To maintain the affordability of our tiered network plans for our members and accounts, we periodically update the tiers with the most current available data.

Reclassifying our network from time to time also encourages network providers to continue to improve their cost and quality performance.

We recently updated the tier placement of hospital and primary care provider groups within our Blue Options plans.

The reclassification is based on cost and quality methodologies that use well-accepted performance measurement principles and validated measures articulated by local and national physician leaders and measurement experts. It also reflects data changes that have occurred since the last update.

The changes are effective for employer groups currently offering a Blue Options plan on the group's first renewal date on or after January 1, 2013 and for all new accounts on or after January 1, 2013.

You can identify members in the updated Blue Options product by the V.4 on their ID card.

You can find the tier status of a PCP or hospital using the Find a Doctor search tool available on our website.

Member communication and benefits

Depending on their Blue Options group anniversary date, members may continue to have the current V.3 plan design until December 2013.

Since accounts may customize their employees' benefit structure, we encourage you to check member benefits and eligibility using our provider technologies before rendering services or collecting copayments.

You will need to know your tier status and the member's version of the plan to collect the appropriate copayment.

Updates being made to Blue Options V.3 and plans with the Hospital Choice Cost Sharing benefit feature

As a result of favorable improvements in Boston Children's Hospital cost performance at three satellite locations, we will update the hospital tiering in our Blue Options benefit designs for V. 3 and for Hospital Choice Cost Sharing benefit design for services at these satellite facilities.

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BCBSMA's Guidelines for Appointment Wait Times and Access to Care

The speed with which members obtain appointments to see their primary care provider (PCP) strongly influences their overall satisfaction with their care.

To benchmark patient satisfaction with appointment wait times across health plans nationwide, BCBSMA looks at Consumer Assessment of Healthcare Providers and Systems (CAHPS) data administered by the Agency for Healthcare Research and Quality (AHRQ). Our own data are then measured against CAHPS standards.

You can find this information in Section 1: Health Plan Overviews of your *Blue Book* manual, available online. Log on to **bluecrossma.com/provider** and click on **Resource Center> Admin Guidelines & Info> Blue Books.**❖

Office Staff Notes

Colonoscopy Screening Benefits Extended for PPO and Indemnity Members

Under the Patient Protection and Affordable Care Act (PPACA), group and individual health plans and group health insurers no longer require cost-sharing for members when they receive certain preventive services, and must provide coverage for some preventive services.*

To address recommendations from national organizations and the U.S. Preventive Services Task Force, we eliminated the age and frequency limitations from our colonoscopy benefits for PPO plans to allow members to be screened more often or at an earlier age if medically indicated. This aligns our PPO plans with our HMO plans, which do not have these limits.

These changes took effect on January 1, 2013:

- For fully insured PPO and indemnity plan designs and
- On account anniversary date on or after January 1, 2013 for self-funded PPO and indemnity plan designs.

National guidelines

National guidelines recommend colorectal cancer screening starting at age 50, then every 10 years.

However, more frequent or earlier screening is recommended for patients with certain increased risk factors, such as a family history of colon cancer or personal history of polyps. Screening in these situations will now also be covered when billed as a preventive service.**

Benefits covered

Under the PPACA, we cover:

- Colorectal cancer screening with colonoscopy, sigmoidoscopy or barium enema when these services are billed as preventive services
- Associated anesthesiology, laboratory, and pathology services.

These preventive services are covered at no cost for members unless the account is grandfathered under the provisions of PPACA and has maintained cost-share for preventive services.❖

**Some grandfathered health plans may still apply a cost share.*

***Self-insured accounts may have more limited benefits.*

Updates to the Outpatient Surgical Day Care List Take Effect on May 1, 2013

Effective May 1, 2013, BCBSMA will implement a new version of the Outpatient Surgical Day Care (SDC) list as a guide to determine the most appropriate setting for services for our members. The list is a working tool and is not intended to be all-inclusive. If you believe the circumstances of the individual member warrant an inpatient setting, prior authorization is required to obtain inpatient coverage. We make all authorization decisions for inpatient services using InterQual®˝ criteria (CMS criteria for Medicare Advantage products). Going forward, we plan to notify you of changes to the surgical day care list online.

The SDC list is based on McKesson's InterQual criteria for medical necessity criteria standards, which is a tool for making level of care determinations. This tool meets industry standards and supports the provision of quality clinical care. InterQual's medical necessity criteria were developed by a national panel of clinical experts and:

- Use evidence-based clinical criteria to measure severity of illness and intensity of service to make medical necessity determinations.
- Contain specific and objective clinical criteria, allowing more consistent application of criteria for effective decision-making.

InterQual's criteria are nationally recognized for their clinical relevancy. They are currently used by many of our hospitals and providers, and by most Massachusetts managed care organizations. McKesson reviews and updates this list annually to validate its recommendations.

To view the SDC list, log on to **bluecrossma.com/provider** and select **Manage Your Business>Medical Review Resources>Surgical Day Care List.**❖

Office Staff Notes

New Blue Care Partnership to Coordinate Care for "Dual Eligible" Medicare and Medicaid Patients

Blue Care Partnership, a joint initiative between BCBSMA and the Massachusetts Behavioral Health Partnership (MBHP), has been selected, pending final review, for a three-year CMS and state demonstration project. This project will test whether an integrated care model can better serve people enrolled in both Medicare and Medicaid (MassHealth). Blue Care Partnership will manage and coordinate the medical, behavioral health, and long-term care needs of such "dual-eligible" Massachusetts adults, ages 21-64, in eleven Massachusetts counties.

Many people with dual eligibility have complex needs due to serious chronic illnesses and disabilities, including mental illness. Creating the right mix of medical care and long-term supports in the community is critical to facilitating high-quality, coordinated care.

"Blue Care Partnership will give members access to the right services and supports by integrating all forms of care—medical, behavioral, pharmacy, dental, vision, and long-term care," said Audrey Shelto, CEO of Blue Care Partnership. "By overcoming the limits of the fragmented health care system they know today and putting individuals at the center of their care plans, we will ensure that members get all the services they need to improve their health, their quality of life, and their level of independence."

The strength of the partnership

BCBSMA and MBHP have extensive experience in managing health benefit plans for Medicare, Medicaid, and commercial members. BCBSMA has 75 years of experience in managing the medical health care needs for its members, and MBHP has 16 years of unique experience in meeting the needs of individuals throughout the Commonwealth who have serious mental illness, substance use problems, or depression.

A person-centered model of care

The goals of this demonstration project are to:

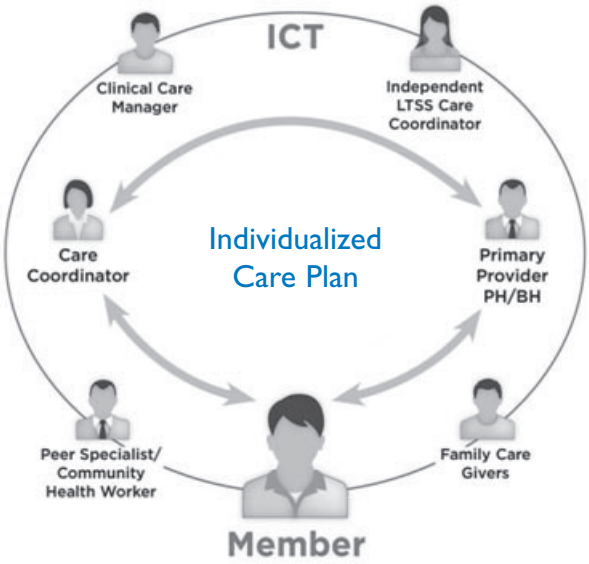
- Give members greater independence at home and in the community
- Avoid excessive hospital and emergency room visits
- Improve the member's care experience.

Each member will participate in developing an Individualized Care Plan (ICP) together with an Individualized Care Team (ICT), which includes a care coordinator, clinical care managers, peer counselors, and other member-identified caregivers. Of course, the ICT will work with the member's PCP, specialists, and other providers to coordinate the member's care.

The Blue Care Partnership will also provide community support services as alternatives to long-term institutional care, as well as diversionary behavioral health services to allow individuals with serious mental health and substance use disorders to stay in the community.

More details to come

Blue Care Partnership is currently preparing for final approval as an integrated care organization (ICO). We will share more details as the effective date approaches. If you have questions in the meantime, please call your Network Manager at **1-800-316-BLUE (2583).**❖



The ICT consists of these caregivers working in conjunction with the member.

Office Staff Notes

Get Into Gear on the HIway: First Health Information Exchange

Early adopters—physicians, health systems and hospitals—have already signed on to the first statewide Health Information Exchange in Massachusetts. Will you connect to the Mass HIway?

What is it?

The HIway allows doctors' offices, hospitals, laboratories, pharmacies, skilled nursing facilities and health plans to easily share clinical information. By leveraging data standards, meaning is maintained across care settings, regardless of the provider's affiliation, location, or differences in technology. For example, if a PCP coordinates care for a patient at a practice in Springfield and refers to ICD-9 code 250.01, the specialist the patient sees in Boston will know the patient was treated by her PCP for type 1 diabetes without complications. This revolutionizes access to information by giving doctors and other clinicians a more comprehensive understanding of their patients' medical histories to inform health care decisions. You can connect via:

- Direct-enabled EHR systems
- Local Area Network Device (LAND)
- Secure webmail portal.

Getting started

Federal and State governments will fund the vast majority of the operating costs for the HIway. The HIway uses a tiered pricing structure, based on organizational size and level of information technology complexity and capability.

Are you on the HIway?

Tell us what you are doing to connect to the HIway, and we may feature your story in a future news article. Send us an e-mail at **focus@bluecrossma.com.**

To learn more, call **1-855-MA-HIWAY (1-855-624-4929)**. Or visit **mehi.masstech.org/what-we-do/mass-hiway.**❖

Use Appropriate Modifiers for Lab Services

When billing for lab codes, remember to use the appropriate modifier (26 or TC) with your claims. Billing without a modifier can result in only one of the two providers involved being reimbursed.

Example: If you are billing for the interpretation of lab results and omit modifier 26, the claim submitted by the lab for the technical component of the service will not be paid. Similarly, if we receive the lab's claim first and it was billed without using modifier TC, the professional component claim will not process for payment.❖

Date of Onset Required for Claim Submission

The date of onset is required information for all UB-04 claim submissions. *It is critical that you include this information in Block 31 with all claims submitted, including those for members of other Blues plans.* Doing so will help to eliminate unnecessary requests for medical records and will expedite claims processing.❖

Office Staff Notes

Focus on HEDIS: Follow-up After Hospitalization for Mental Illness

Discharge planning for a patient who has been hospitalized for mental illness should start at the time of admission. For improved coordination of care, the patient's behavioral health provider(s) and his or her PCP should be contacted. **Best practice requires a patient who has had an inpatient mental health stay to have a scheduled follow-up appointment with a behavioral health care provider within seven days of discharge.**

Careful discharge planning helps to stabilize the member upon discharge, prevent readmission, and is essential in maintaining community tenure.

HEDIS measure and scores

We share our HEDIS scores with you to help provide context for improved performance on follow-up care. Below are the measure and the BCBSMA scores.

HEDIS Measure: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.

HEDIS FUH scores for BCBSMA providers versus top performance (90th percentile) nationally

Measure:	BCBSMA HMO/POS:	National HMO 90th Percentile:	State Avg:	BCBSMA PPO:	National PPO 90th Percentile:	State Avg:
The percentage of discharges for which the member received follow-up within 7 days of discharge	68.39%	76.21%	76.92%	69.77%	67.53%	72.24%
The percentage of discharges for which the member received follow-up within 30 days of discharge	84.97%	89.21%	89.35%	85.17%	83.78%	85.16%

(*Source: NCQA Quality Compass 2012*) ❖

Working together to improve performance

It is important that a patient who has been hospitalized for mental illness leave the facility with a follow-up appointment scheduled with a behavioral health provider within seven days of discharge. If you need help implementing this best practice and are trying to assist the member in scheduling an appointment within seven days of discharge, you can contact our Behavioral Health Care Coordination area at **1-800-444-2426**. We can help coordinate the follow-up care.❖

Blue Benefit Administrators of MA Transactions Must be Submitted to BBA

As of December 2, you must submit all Blue Benefit Administrators of MA (BBA) eligibility benefit inquiries, claims status requests, referral status and claims submissions directly to BBA. We will no longer redirect transactions erroneously submitted to BCBSMA.

If a BBA transaction is submitted to BCBSMA, the submitter will receive a rejection message instructing that the inquiry or claim must be submitted directly to BBA. Our provider *Blue Book* manuals include a BBA appendix with contact information and claims submission instruction.

To access, go to **bluecrossma.com/provider** and select **Resource Center>Admin Guidelines & Info>Blue Book**. Or, go to **bluebenefitma.com** for more information about submission options and online resources.❖

Office Staff Notes

Chapter 224 and Physician Assistants: Expanding Access to Care

Massachusetts law[1] expanded access to primary care by broadening the scope of practice of physician assistants (PAs) and adding them as primary care providers. So, what is Blue Cross Blue Shield of Massachusetts doing?

Credentialing and contracting PAs in 2013

In 2013, we will verify credentials through HCAS and contract with PAs in Massachusetts to expand access to care for our members. There are many aspects of this change in practice scope that we must consider, and we want to make sure we do so in a thoughtful manner. We want PAs to have the best implementation experience possible—from the contracting and credentialing process to billing, reimbursement, and access to our technologies—so we have been working together with the Massachusetts Association of Physician Assistants (MAPA) to get valuable input on these topics.

All PAs whose services are billed on a CMS-1500 claim form will have the opportunity to contract with us. At this time, our plan is to have three categories of PAs as listed below.

Category:	Description:
PA-PCP	PA-PCPs have their own panel of patients and would be listed as a primary care provider (PCP) in our provider directories so that members could choose the PA as their PCP
PA (primary care practice)	PAs who work in primary care and have elected not to be recognized by Blue Cross Blue Shield of Massachusetts as a PA-PCP
PA (specialty practice)	PAs who work in a specialty care practice

More information will be shared when plans are finalized

We'll continue to work with the local professional society in Massachusetts, MAPA. When more information is available, we will post updates on our provider website and will be in contact with PAs. On behalf of our members, we look forward to working with PAs to expand access to care.❖

[1] Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation."

Blue Focus Going Digital in 2013

To enhance delivery of provider news, we will issue updates exclusively through our provider website and e-mail starting in 2013.

This means you will no longer receive a printed version of *Blue Focus* in the mail.

In addition to being faster and more convenient, the digital format allows us to maintain a company-wide commitment to reduce paper use, waste, and energy.

If you have questions about this change, please e-mail **focus@bcbsma.com.**

If you need assistance with registration or technical support please contact the Provider Self Service Help Desk at **1-800-771-4097** M-F 8:00 a.m.-4:00 p.m. EST, or by email at **Provider.Self.Service@bcbsma.com**

Office Staff Notes

Improving Cost and Quality Transparency in Health Care for Members and Providers

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- Access to provider group-level clinical quality results and patient experience surveys, and for hospitals, HCAHPS patient experience data.
- For select PPO members, we are piloting an enhanced out-of-pocket cost estimator tool that allows members to compare the approximate cost of 128 services and procedures that can be performed in a variety of settings (e.g., hospital outpatient, inpatient, freestanding imaging centers, ambulatory surgery centers) to estimate their out-of-pocket cost.

We have created a special provider version of the tool that will include referral circle information and providers' NPIs to aid you in making referrals, along with all the features above (except the out-of-pocket estimator).

We will share more details on the provider version of Find a Doctor in future issues of *Blue Focus*.

Plan design also shapes consumer decision-making

Plan design also helps consumers make decisions based on quality and cost. During 2013, tiered network plans will start using Blue Options V.4 with PCP and acute care hospital tier classifications that have been updated with the most recent quality and cost data. Members pay the lowest cost share when they receive care from PCPs and hospitals in the Enhanced Tier, representing the lowest cost and highest quality; they pay a higher cost share when they receive care from providers in the Standard and Basic tiers.

We have also updated our Hospital Choice Cost Sharing benefit feature. Members with this benefit feature have substantial out-of-pocket costs for hospital, lab, and radiology services delivered by facilities in the Basic tier of our Blue Options network. Our online Plan Education Center offers tools to help members understand their plan, including a list of low-cost laboratories and imaging providers.❖

Reminder About BCBSMA's Standards in Utilization Management

We would like to remind you that our utilization management decisions are based only on appropriateness of care and existence of coverage. BCBSMA does not reward practitioners or other individuals for issuing denials of coverage, and BCBSMA has no financial incentives for utilization management decision makers that encourage decisions that result in underutilization.

You can find BCBSMA's standards in Utilization Management at: **bluecrossma.com/provider**. Select **Resource Center>Admin Guidelines & Info>Blue Books**, then select **Section 2.**❖

Billing Notes

New Claim Adjustment Reason Code on 835 Transactions

We have started to report claim adjustment reason code OA/187 on 835 transactions. You may now see this code if you have a direct connection with us, or if you receive online remittances and posting reports through PaySpan.

Please be aware of this when reconciling patient accounts.

OA/187 is used to indicate a patient who has used a consumer spending account (including, but not limited to, a flexible spending account, health savings account or health reimbursement account) to pay for a particular service performed.

If you have questions about OA/187, please e-mail **EDISupport@bcbsma.com** or call our EDI team at **1-800-771-4097.**❖

Medical Policy Update

Medical Policy Announcements

Our website now provides announcements of new and revised medical policies. It is fully searchable to make it easier to find the policies and revisions that are of interest to you.

The list of new and revised policies is now available. Log on to **bluecrossma.com/provider, select Manage Your Business>Review Medical Policies.** Located at the top of the page, click on **View Medical Policies** and in the middle of the next page, select **Medical and Pharmacy Policy Updates.** The list is organized alphabetically by policy title. Clicking on the policy title will link you to its entry in a summary table within that document.

Reminder: Medical policies have a new look

We want to remind you that BCBSMA is reformatting our medical policies. You will begin to see these simplified policies this month. Medical Policy Administration will continue to announce all policy changes 90 days in advance. Our website now provides announcements of new and revised medical policies. It is fully searchable to make it easier to find the policies and revisions that are of interest to you.

Coding on revised BCBSMA medical policies

In preparation for the transition to ICD-10 in 2014, BCBSMA has reviewed all the coding associated with our medical policies to assure that the current, familiar ICD-9 coding is correct. Please review the updated coding section on each policy. These codes most accurately reflect our medical policy statements and may differ from earlier policy versions.❖

Our Revised Tiered Network Plan—Blue Option V.4—is Now Available

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Boston Children's locations in Lexington, Waltham, and Peabody will move to the Standard Benefits Tier for Blue Options and to Lower Cost Share for Hospital Choice Cost Sharing. As a result, members will have lower out-of-pocket costs. The updates took effect in a one-day change for all Blue Options plans and accounts on January 1, 2013.

The main campus of Boston Children's Hospital will remain in the Basic Benefits Tier/Higher Cost Share.

Reminder: Depending on where they receive care, members with our Hospital Choice Cost Sharing benefit design pay differing cost share for inpatient care, surgical day care services, and outpatient services including diagnostic high-tech radiology, diagnostic X-rays and other imaging tests, diagnostic lab tests, and short-term rehabilitation therapy.❖

Ancillary News

2013 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, 2013 to make any applicable fee schedule changes.

This year's update includes significant changes to codes billed by behavioral health providers.

You may also wish to consult with your professional society and the CPT coding update manual to learn how these codes replace codes you currently use.

Please remember:

- Do not bill for deleted codes after January 1, 2013.
- Bill only for codes that are on your current Agreement. We only provide reimbursement for codes included on your Agreement.

We anticipate posting changes (including any additions, deletions, and narrative changes) and a revised fee schedule online early in 2013.

We have sent behavioral health providers more information about the code changes that affect them.

For all other ancillary providers, we will only communicate these updates via our BlueLinks for Providers website and will not send a printed *F.Y.I.* If you have not already done so, we urge you to register for updates via e-mail.

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

Pharmacy Update

Update on Formulary Changes for 2013

We previously announced that all ophthalmic solutions used to treat allergies would be excluded from coverage under our pharmacy benefits. This took effect on January 1, 2013 for all commercial members, Medex®′ group members who have BCBSMA pharmacy coverage, and Managed Blue for Seniors℠ members.

Since making that announcement, we have decided not to exclude Alrex from coverage because an over-the-counter alternative for this steroid is unavailable to our members. If you prescribe Alrex to your patients, please be aware that you must request a formulary exception for coverage as a Tier 3 medication.

If you have questions, please call Clinical Pharmacy Operations at **1-800-366-7778.**❖

Medicare Advantage Pharmacy Updates

Short-cycle dispensing of brand name medications is required

Effective January 1, 2013, CMS requires solid, oral doses of brand-name drugs to be dispensed in 14-day or less increments to patients staying in long-term care facilities.

Medication described as "difficult to dispense," such as blister packs and prescriptions that cannot be split conveniently or accurately, are excluded from this mandate.

This change is expected to help reduce drug diversion and unnecessary dispensing of prescription drugs.

Opioid drug management to expand to Medicare Advantage patients

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 population to help facilitate safe, appropriate use of these medications. This is part of our continued effort to reduce the risk of opioid prescription drug abuse.

We are currently reviewing claims data and may be reaching out to you to provide information to help improve prescription drug safety among this population.❖

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Not registered for BlueLinks for Providers?

Go to **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 Network Management and Credentialing Services 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 Network Management and Credentialing Services at **1-800-316-BLUE (2583).**
- **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 **bluecrossma.com/provider** and click on **Medical Policies.**❖

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