March 2013

Providerfocus

Published Monthly for Physicians, Health Care Providers, and Their Office Staff

MASSACHUSETTS

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Healthbox Kicks Off Second Boston Accelerator Program This Month

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 is continuing its partnership with Healthbox in 2013 as part of our commitment to addressing health care challenges through the development of innovative solutions.

This year, Healthbox will give 10 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 health care entrepreneurs

Healthbox has invited entrepreneurs with early-stage health care technology-enabled startups to apply. The selected 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 groundbreaking ideas to life that have the potential of improving the health care eco-system."

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.

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.

Interested in learning how to participate? Please contact Jen Ferrari at **jennifer.ferrari@bcbsma.com** or Angela Cassidy at **angela.cassidy@bcbsma.com**. For more details, visit **healthbox.com.**❖

In This Issue

In Brief

Provider Focus Going Digital in 2013

To enhance delivery of provider news, starting later this year we will issue news and important administrative updates exclusively through our provider website. This means you will no longer receive *Provider Focus* in the mail.

In addition to being faster, the digital format allows us to further our company-wide commitment to reduce paper use, waste, and energy.

We will send you more details as we get closer to publishing news solely online. If you have any questions in the meantime, please e-mail **focus@bcbsma.com.**

To verify or update your e-mail address currently in our system, please log on to **bluecrossma.com/provider**. In the "**Manage My Profile**" box on the left-hand side of the home page, click on **Edit My Profile.**❖

Physician News

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 spending in non-participating groups. Savings were substantially larger in the groups that had no experience with risk-based contracts—6.3% in year one and 9.9% in year two. In 2011, savings were generated in two key areas:

- **Improved use of health care** - 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.

The most common examples of the types of sustainable changes in the way groups and individuals practice that interviewees cited included:

- 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.***❖

Physician News

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 Health Care Administrative Solutions, Inc. (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 outlined 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."*

DEA Policy Clarification

If you are a practitioner with legal authority to prescribe medications, then BCBSMA requires you to hold:

- An appropriate, current, and valid Federal DEA Certificate of Registration with a Massachusetts office address in good standing, and
- An appropriate Massachusetts Controlled Substances Registration (MCSR) as applicable.

The following practitioners are not required to hold a DEA or MCSR:

- Dentists whose practice is limited to orthodontics
- Dentists who work exclusively in a dental school
- Dentists with limited licenses practicing at community health centers
- Clinical/Medical Geneticists
- Pathologists
- Diagnostic Radiologists

Optometrists are required to have an MCSR only.❖

Physician News

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

The table above demonstrates that less than half of our member population is receiving the recommended treatment for AOD. It's important to remember that 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. Here are some scenarios that are identified as 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 PCPs use the Screening, Brief Intervention, Referral and Treatment (SBIRT) model, an evidence-based practice model of care, to address AOD in your patients. The SBIRT model allows 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 *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. The AOD diagnosis should be reported in all follow-up visits. ❖

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 is important in order to accurately reflect the patient's health status and medical record documentation. This will help to avoid inappropriate identification of patients for care management services by provider organizations or health plans. 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 code for the diagnosis you suspect your patient has.
Outpatient care	Should **NOT** be coded. 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).

Billing Notes

New Claim Adjustment Reason Code on 835 Transactions

When reconciling patient accounts, please be aware that we have started to report claim adjustment reason code OA/187 on 835 transactions. OA/187 is used to indicate a patient—our member—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. You may see this code if you have a direct connection with us, or if you receive online remittances and posting reports through PaySpan.

If you have questions about OA/187, please e-mail **EDISupport@bcbsma.com** or call our EDI production support team at **1-800-771-4097** and select **option 4.**❖

Pharmacy Update

Two Opioid and Pain Management Programs for Medicare Advantage Members

Inadequate pain management and prescription opioid addiction and abuse are growing public health issues. As we noted in the January/February issue of *Provider Focus*, 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. Prescriber intervention will be required before it can 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.❖

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.❖

ACE/ARB Therapy Reminder

Some physicians will receive a letter from our pharmacy benefit manager, Express Scripts, Inc., that lists patients in their practice who have been identified as potentially benefitting from a change in medication therapy.

The patients identified may either be using high-risk medications, or they may be hypertensive diabetics currently not on ACE/ARB therapy.❖

Ancillary News

DME Providers: Important Billing Information for Electronic Claims

We've noticed an increase in claim rejections due to missing referring/ordering providers' names and NPIs on electronic claim submissions (837 transactions). We would like to remind you what you need to include on electronic claims, so that you receive timely reimbursement. Please see the chart below.

If you have questions about your claims, please contact Provider Services at **1-800-451-8124.**❖

Please be sure to complete the following fields on your 837 professional electronic submissions for referring/ordering provider name and NPI:

Use this field:	To indicate:	Example:
Loop 2310A Element NM103, NM104 (claim level)	The referring/ordering provider's name. **This is a required field.**	Here's an example of a complete submission for loop 2310A: NM1*DN*1*Last Name*First Name*MI***XX*1234567891~
Loop 2310A, Element NM109 (claim level)	The referring/ordering provider's NPI. **This is a required field.**	
Loop 2420E Element NM103, NM104 (line level)	The referring/ordering provider's name. Use this line level only when the provider's name differs from the one listed on the 2310A. This may happen in instances in which there is more than one provider who ordered services that are billed on the same claim.	Here's an example of a complete submission for loop 2420E: NM1*DK*LastName*FirstName*MI**XX*1204567091~
Loop 2420E Element NM109 (line level)	The referring/ordering provider's NPI. Use this line level only when the provider's NPI differs from that listed on the 2310A. This may happen in instances in which there is more than one provider who ordered services that are billed on the same claim.	

If you use InfoDial

You cannot use InfoDial®′ to submit these claims anymore. Please sign-up for Direct Data Entry, an online claim submission tool, via BlueLinks for Providers to fulfill this claim submission requirement. This tool is available at no cost to you. You may also submit these claims on a CMS-1500 claim form.

Submitting Claims through Direct Data Entry via Online Services

The referring/ordering provider information now appears in Section 9 to accommodate these billing requirements; however, they are not highlighted in pink.❖

MEDICARE ADVANTAGE

QUALITY CARE NEWS

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:

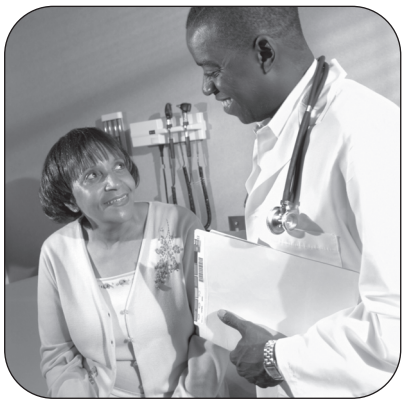
- Having a routine annual visit
- Discussing health concerns with their physician
- Following clinician advice, asking questions, and following up as indicated.

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.**

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 cumbersome 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. ❖

Blue Benefit Administrators of MA Transactions Must Be Submitted to BBA

As of December 2012, you must submit all Blue Benefit Administrators of MA (BBA) eligibility and benefits queries, claims status requests, referral status inquiries, and claims submissions directly to BBA. We will no longer forward transactions erroneously submitted to BCBSMA to BBA; you will just receive a message reminding you that the inquiry or claim must be submitted to BBA.

Our provider *Blue Books* include a Blue Benefit Administrators appendix with contact information and claims submission instruction.

Just log on 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

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 and 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 review of PCP medical record documentation is no longer required by NCQA, our final review of PCP records 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.❖

We Have New Expanded Eligibility System Hours

As of January 1, 2013, to better serve you, we have expanded our eligibility system hours. BCBSMA can now process eligibility and benefit transactions, both real-time and batch, Monday through Saturday, 24 hours a day, except for the following major holidays:

- New Year's Day (1/1)
- Memorial Day (5/27)
- Independence Day (7/4)
- Labor Day (9/30)
- Thanksgiving Day (11/28)
- Christmas Day (12/25)

Routine maintenance may be performed on Sundays.

For additional information, please refer to our *HIPAA Transaction 270/271 Companion Guide.*❖

Submit Claims Online Via Direct Data Entry in Online Services

To simplify the way you do business with us, we now offer participating providers the ability to submit CMS-1500 claim forms via direct data entry in Online Services.

You can use Online Services to submit any professional claim when BCBSMA is the primary payer and no supplemental documentation is required.

Benefits of submitting claims via Direct Data Entry

- On average, claims submitted electronically are paid more quickly than paper claims.
- No special software is required; simply key in your claim information.
- You can easily copy, edit and re-submit claims.
- You can track and manage submitted claims with the reports you receive using the Reporting & Analytics feature.

To learn more sign into **bluecrossma.com/provider** and click the **Direct Data Entry** portlet.❖

Office Staff Notes

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.

Coding on revised BCBSMA medical policies

In preparation for the transition to ICD-10 in 2014, BCBSMA has reviewed all 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.❖

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.❖

New Training Available: Timely Filing Guidelines

Denials for claims submitted over the timely filing limit are among the most common claim denials. Learn how to avoid this type of a denial in just seven minutes through an online program that you can take at your convenience.

You'll learn the timely filing guidelines for different BCBSMA product types and for secondary claims, as well as how to submit an appeal.

To view the presentation, log on to **bluecrossma.com/provider**, go to **Resource Center> Training & Registration> Course List**, and select **Timely Filing Guidelines.**❖

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Please route to:
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- ☐ **Physician**
- ☐ **Nurse**
- ☐ **Billing manager**
- ☐ **Billing agency**
- ☐ **Receptionist**
- ☐ **Other:** _____

At Your Service

- BlueLinks for Providers
  bluecrossma.com/provider
  Our website has the resources to help you care for our members, and offers you the ability to check claim status, and eligibility and benefit information. Available 24 hours a day, 7 days a week.
- Claims-related issues:
  Provider Services: **1-800-882-2060**
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
  Ancillary Provider Services: **1-800-451-8124**
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
- Fraud Hotline: **1-800-992-4100**
  Please call our confidential hotline if you suspect fraudulent billing or health care activities.
- Non-claims-related issues:
  Network Management & Credentialing Services:
  Reach your Network Manager or inquire about contracting and credentialing issues (all provider types):
  1-800-316-BLUE (2583)
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.

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