January/February 2013

Providerfocus

MASSACHUSETTS

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

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

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 members 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.
- 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).

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In This Issue

In Brief

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.**❖

Physician News

Focus on HEDIS: The Importance of Antidepressant Medication Management (AMM)

HEDIS' AMM measure has two components, shown in the table below. The measure evaluates members 18 years of age or older. We are sharing our results to provide you with some context to improve your treatment of members suffering from depression.

Identifying depression

Recognizing and diagnosing depression is the first step in developing effective treatment options for patients. We suggest use of the Patient Health Questionnaire-9 (PHQ-9) for routine screening to identify patients needing more detailed diagnostic assessment.

Patients suffering from moderate to severe depression who stay on medication for at least six months have a greater chance of having their depression treated to remission, which reduces the likelihood of future relapse.❖

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

Measure:	BCBSMA HMO/POS:	National HMO 90th Percentile:	BCBSMA PPO:	National PPO 90th Percentile:
Effective Acute Phase Treatment - percent of newly diagnosed and treated members who remain on anti-depressant medication for at least 84 days (12 weeks)	71.26%	73.43%	69.57%	70.41%
Continuation Phase - percent of newly diagnosed and treated members who remain on anti-depressant medication for at least 180 days (6 months)	55.95%	57.75%	54.60%	55.43%

(*Source: NCQA Quality Compass 2012)*

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.**❖

Physician 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 on **bluecrossma.com/provider,** 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.❖

Members Invited to Join Study Promoting Medication Adherence

Up to 69% of all medication-related hospital admissions in the United States result from patients not taking their medications as prescribed[1]. Beginning in January, an outside clinical research group is inviting select BCBSMA members to participate in a study investigating ways to help patients take their medications as prescribed to improve their health. At this time, the research team is not accepting referrals into the study, but we want you to be aware of the study in the event a patient mentions it to you.

[1] Osterberg, M.D., and Blaschke, M.D, "Adherence to Medication," N Engl J Med (August 2005, 353:487-497).

Website Updated with Condition-specific Information

On our website, we share information and resources on more than 20 different medical and behavioral health topics, ranging from asthma and diabetes to substance abuse. We've recently updated much of this information to include:

- Updated recommended clinical guidelines
- Information about our health management programs for members with chronic conditions
- Resources for patients available on our member websites.

To learn more, log on to **bluecrossma.com/provider** and select **Manage Your Business> Manage Patient Care**. Use the drop-down menu to select the health topic of your choice.❖

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.**❖

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 Corner: ICD-9-CM Diagnostic Coding for Fractures

When billing for patients receiving fracture care, you must distinguish between services for patients receiving active treatment of a new fracture from services they receive once active treatment is completed. Your office notes should also indicate whether the fracture is due to a pathological condition (such as osteoporosis) or a traumatic injury since there are different codes for each fracture type.

Proper claim coding of new fractures ensures that we receive an accurate rating for the HEDIS osteoporosis measure, which rates the care management for women over 67 who had a newly diagnosed fracture. Incorrectly coded claims result in members being mistakenly included or excluded from the measure.

The table below explains appropriate coding for fractures and aftercare according to the ICD-9-CM Official Guidelines for Coding and Reporting. By coding correctly, you will assist us in identifying the right members for this measure, ensuring a more accurate HEDIS osteoporosis score, and a more accurate representation of your practice.❖

When treating your patients for:	And the patient:	Use this ICD-9-CM code:
A newly diagnosed pathological fracture	Is receiving active treatment for the fracture, i.e., surgical treatment, emergency room encounter, evaluation and treatment by a new physician	Pathological fracture code from subcategory 733.1
Aftercare of a pathological fracture	Has completed active treatment of the fracture and is receiving routine or follow-up care during the healing or recovery phase	Aftercare codes from subcategory V54.2 **Example:** V54.2X– Aftercare for healing pathological fracture.
A newly diagnosed traumatic fracture	Is receiving active treatment for the fracture, i.e., surgical treatment, emergency room encounter, evaluation and treatment by a new physician	Acute fracture codes from category 800-829
Aftercare of a traumatic fracture	Has completed active treatment of the fracture and is receiving routine or follow-up care during the healing or recovery phase	Aftercare codes from subcategory V54.1 **Example:** V54.1X Aftercare for healing traumatic fracture.

Physician News

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:

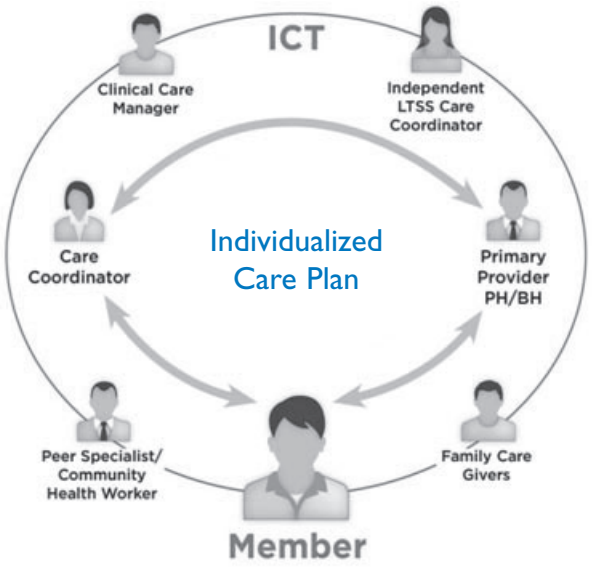
- Give members greater independence at home and in the community
- Avoid excessive hospital and emergency room visits
- Improve the member's care experience.

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.

MEDICARE ADVANTAGE QUALITY CARE NEWS

Medicare Health Outcome Survey Set for Spring

The Medicare Health Outcome Survey (HOS) is the largest member survey effort ever undertaken by CMS. It is designed to improve preventive care by making public valid, reliable health status data. All Medicare Advantage plans must participate.

How are HOS scores collected?

Every spring, 1,200 randomly selected beneficiaries from each Medicare Advantage Organization are surveyed; two years later, they are asked to rate specific indicators of their health as better, the same, or worse.

Our focus on HOS

In 2012, we focused on the following five HOS indicators in our communications with members and providers:

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

You can make a difference

Engaging your patients about these issues of aging can be challenging, but we encourage you to continue to do so. Many physicians find that their patients are more open to these conversations during routine visits, before symptoms arise.

To complement and support your efforts to help patients deal with the challenges of aging and maintain functional status, we will continue to outreach to members in 2013 and to encourage them to discuss these sensitive topics with you.

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

Health Risk Assessments Help You Manage Care

We regularly conduct health risk assessments (HRAs) for our Medicare Advantage HMO Blue℠ and Medicare Advantage PPO Blue℠ members to find patients who may benefit from medical management programs.

Licensed and credentialed nurse practitioners and physician assistants from Matrix Medical Network, a national medical assessment organization, conduct these voluntary in-home health assessments on our behalf. These assessments help our members better understand and manage their health needs.

PCPs whose patients are assessed will receive a copy of the HRA. Please review it for opportunities to identify gaps in care and provide more comprehensive care to your patients. To improve and manage your patient's care, we recommend you keep the HRA with the patient's medical record to review during their next office visit.

If you have any questions about the Matrix HRA, please contact Network Management Services at **1-800-316-BLUE (2583).**❖

Training on ICD-9 Coding and Documentation for Chronic Conditions Now Online

Did you miss the opportunity to attend the Altegra Health™ ICD-9 coding webinar? If so, we are providing an audiovisual recording of the webinar for a limited time. Just log on to **bluecrossma.com/provider** and click on **Resource Center>Training & Registration>Course List.** Under the **Primary Care or Specialty Care** menu, select **Medical Documentation and Coding: A Focused Look.**❖

Office Staff Notes

Electronic Claim Submission Is The Most Efficient Way to Submit Claims

Electronic claim submission is the fastest, most efficient way to submit claims to BCBSMA. We offer several options to meet your business needs, achieve efficiency, and reduce costs:

- Direct Submission to BCBSMA. There is no cost for a direct connection, but you must be able to create a compliant 837 file.
- Third-party Vendor. Vendors offer reporting that allows you to track your revenue and connects you to multiple payers.
- Direct Data Entry. This no-cost, web-based option offers you reports that confirm claim receipt and lets you create patient and favorite lists for quick claim entry. It eliminates the time required for mailing your claim to us.

To decide which is the best solution for you, visit **bluecrossma.com/provider** and select **Manage Your Business** or call our Provider Self Service Team at **1-800-771-4097**.

If you must submit paper claims, use only the red CMS-1500 (08/04) form. More tips for paper claim submission can be found in *The Plans' Supplement to the NUCC 1500 Claim Form* on **bluecrossma.com/provider**. Select **Resource Center> Admin Guidelines and Info.** Under **Billing Resources**, select **Paper 1500 Billing Guidelines for Professional Providers.** ❖

Requesting Individual Consideration Claim Adjustments

To request a claim adjustment for services that have previously been reviewed for individual consideration, you must submit a written request for claim review. Provide the details of the change requested in the comment section of the *Request for Claim Review* form and include supporting reports and an invoice, if applicable, to expedite your request.❖

To:	Follow these instructions:
Download the *Request for Claim Review* form	Log on to **bluecrossma.com/provider** and click on **Resource Center>Forms.** Scroll to the **Review and Appeals section**.
Find more information on reviews and appeals	Log on to **bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books**. Select **Section 4** and read the **Reviews, Appeals, and Audits** section.
Submit a request for claim review by Individual Consideration Staff	Mail to: Blue Cross Blue Shield of MA Provider Appeals P.O. Box 986065 Boston, MA 02298
Ask a question about this process	Please call **1-800-882-2060**.

Office Staff Notes

Annual HEDIS Medical Record Review Begins in February

This year, BCBSMA will conduct our annual medical record review to meet NCQA Healthcare Effectiveness Data and Information Set (HEDIS) reporting obligations rather than using a vendor. We look forward to collaborating with you and learning how we can further support your delivery of high-quality health care.

We may request information from your practice for a sample of our HMO/POS and PPO members. All medical record information collected will be handled in accordance with HIPAA regulations. We will examine the documentation promptly and provide timely feedback when additional information or clarification is needed. As you know, PCPs are required to participate in quality improvement initiatives.

Questions?

Please contact our HEDIS Medical Records Collection Team at **1-888-99-HEDIS (43347)** or e-mail **HEDIS@bcbsma.com.**❖

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.**❖

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.❖

Condition Date Required For Claim Submission

The date of condition is required in Block 14 for all CMS-1500 claim submissions. It is critical that you include this information 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

How to Check a Provider's CAQH ID Number

After you notify us of a new practitioner joining your practice, you can find his or her CAQH ID number by:

1. Calling CAQH directly at **1-888-599-1771**. When you call, you will need to provide three practitioner identifiers such as practitioner name, date of birth, social security number, national provider identifier.

2. Accessing the CAQH Universal Provider Data Source (UPD) Practice Manager's Module.

3. Checking the CAQH roster to see if the practitioner has been added. You may want to ask about CAQH status when contracting with him or her.

We remain committed to adding new practitioners to the CAQH database in a timely manner to process your credentialing application quickly. If you have any questions, please call Network Management and Credentialing Services at **1-800-316-BLUE (2583)**.

Reminders about recredentialing

To expedite recredentialing, be sure to update or complete your CAQH online application with your most current information. One of the most common reasons for delay in recredentialing is due to expired malpractice insurance information. Please include the most current dates of coverage for your malpractice insurance.

Your recredentialing is due in your birthday month every two years. For example, if your birth year ends in an even number, your recredentialing will occur each even year.❖

How to Submit Address and Telephone Number Changes to Us

Having your accurate address and telephone information enables us to give members the most up-to-date information through our provider directories.

To update the primary site address, billing address, or telephone number for individual providers, you will need to update both your recredentialing application through CAQH (**caqh.org**) *and* submit a *Change of Address* form to BCBSMA. Updating the CAQH recredentialing application alone will not change your address in BCBSMA's records; you must also submit changes in writing to us.

The "Primary Telephone Number" you indicate should be the number a patient would call to schedule an appointment.

If you are affiliated with a group and you are leaving a group practice/location, joining a different group, or adding a secondary site, you will need to complete a *Contract Update* form.

Both forms are found on **bluecrossma.com/provider**. Click on **Resource Center>Forms>Administrative Forms**, then select the appropriate form. Please fax the completed form to us at the number listed. You cannot use the CMS-1500 claim form to notify us of address changes.❖

Filing Limits for Coordination of Benefits and Third-Party Liability Claim Submissions

As a reminder, effective February 1, 2013, we are changing the timely filing guideline for PPO secondary claim submissions to 90 days from the date of the primary carrier's denial. The change from the current deadline (one year) to 90 days is consistent with our filing limit for HMO and PPO initial claim submissions. You will have 90 days to resubmit any HMO, PPO and Medicare Advantage secondary claims to us that have been denied by a primary payer.

We mailed you an *F.Y.I.* about this change in December 2012; to review it, log on to **bluecrossma.com/provider** and select **News For You>FYIs** and scroll to the *F.Y.I.* named **Filing Limits for Coordination of Benefits and Third-Party Liability Claim Submissions (PC-1507)**.❖

Office Staff Notes

Improving Cost and Quality Transparency in Healthcare for Members and Providers

continued from page 1

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

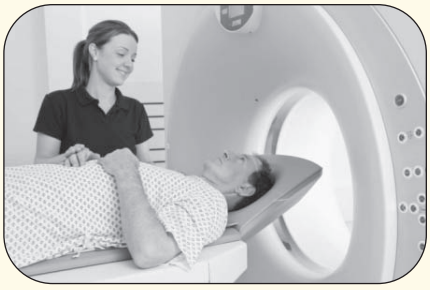
We have also updated our Hospital Choice Cost Sharing benefit feature. Members with this benefit feature have substantial out-of-pocket costs for hospital, lab, and radiology services delivered by facilities in the Basic tier of our Blue Options network. Our online Plan Education Center offers tools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

Transparency About Imaging Becoming a National Trend

Large employer groups are becoming more proactive about managing their employees' health care costs. For example, Walmart, PepsiCo, and Kroger are starting an integrated imaging management program in 2013 administered by Anthem/BCBS of Arkansas in partnership with AIM Specialty Health. BCBS Arkansas will prospectively apply evidence-based clinical guidelines for elective, outpatient CT, MRI, Nuclear Cardiology, PET and Echocardiography exams.

When you provide care to members of these accounts, please check eligibility and benefits to determine if authorization or review is required. If it is, contact AIM using AIM's ProviderPortal℠, **aimspecialtyhealth.com/goweb,** or call the telephone number on the back of the member's ID card. The member may also initiate the request.

AIM will share imaging facility cost data from the Association's National Consumer Cost Tool with the ordering physician's staff during clinical review, and will outreach to patients (excluding pediatric and cancer patients) to inform them of low-cost imaging facility options. Patients will not



be denied services if they select a higher-cost option, but will be informed about potential out-of-pocket savings that will be of particular interest to those members whose plans have coinsurance, reference-based pricing, or high deductibles.❖

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.**❖

Medical Policy Update

Medical Policy Announcements Effective April 1, 2013

Our website now provides the 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 effective April 1, 2013 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 new look

We want to remind you that BCBSMA is reformatting our medical policies. You will begin to see these simplified policies this month. Only the format has changed; we will continue to announce any coverage revisions through our regular process.

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.❖

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ROUTING BOX
Date received:_____
Please route to:
- ☐ **Office manager**
- ☐ **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.

Providerfocus is published monthly for BCBSMA physicians, health care providers, and their office staff. Please submit letters and suggestions for future articles to:

Editor, *Provider Focus*
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