October/November 2012

Providerfocus

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

New Health Management Programs for Members with Chronic Conditions

We know you want to provide the most effective health care possible to your patients. To help our members access effective services, we regularly review the range of health management and wellness programs that we offer. These programs guide our members as they pursue healthy behaviors and offer reinforcement when additional support could be beneficial.

Since many members identified for our current health management programs are diagnosed with one or more major chronic conditions—asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes, and heart failure—we have decided to increase our focus on these five conditions. We'll do this through our new Chronic Condition Management (CCM) Program, starting in late 2012.

The program features new ways to identify, stratify, engage, and support members with chronic illnesses. It will feature an integrated approach that includes appropriate communication with members and providers, and will allow us to better collaborate with our AQC providers to help them treat members with the greatest risk.

As part of the identification process, we will use medical and pharmacy claims data, self-reported assessment information, and lab results (when available).

Members that we follow will receive an intervention designed to help them more effectively manage their chronic condition in accordance with their physician's treatment plan. These interventions may include:

- Educational and informational materials to help them understand and manage their medications
- Methods to plan for effective doctor visits
- Lab and medication reminders.

How to Refer a Member for One of Our Programs

To refer BCBSMA members for chronic condition management or case management programs, download our *Patient Referral Form for Health Management*, available on our website. Log on to **bluecrossma.com/provider** and select **Resource Center> Forms>Practice Management Tools**. After completing the form, fax to the appropriate number listed on the form.❖

Some members will receive additional telephonic coaching from BCBSMA nurses using evidence-based guidelines. We will also continue to offer intensive case management for members with medical and/or behavioral health conditions.❖

In This Issue

In Brief

Electronic News Coming Your Way in 2013

As part of BCBSMA's company-wide commitment to reduce paper use, waste, and energy, we have decided to eliminate *Provider Focus* in the spring of 2013.

Instead of printing and mailing a newsletter to you each month, we'll provide news and updates electronically on our provider website and via e-mail.

That means you'll be able to get your news faster and in a more convenient format.

We will provide more details on this exciting change in the coming months. In the meantime, if you have any questions, please send an e-mail to **focus@bcbsma.com**.❖

Physician News

Focus on HEDIS: The Importance of Entering BMI in Medical Records

As you know, it is important when conducting physicals for your patients to include not only height and weight in their medical records, but also body mass index (BMI). Properly tracking this information will provide a fuller picture of your patient's health.

Here are some tips to help ensure complete medical record documentation for the HEDIS BMI measures for adults, children, and adolescents:

Adult BMI Assessment

This HEDIS measure looks at the percentage of adults, ages 18 to 74, who had an outpatient visit and whose BMI was documented during the measurement year or year prior. Be sure to document in the medical records the:

- Date of the visit
- Patient's weight and height
- Patient's BMI value (notation of height and weight only does not meet HEDIS criteria.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

This measure looks at the percentage of children and adolescents, ages 3 to 17, who had an outpatient visit with a PCP or OB/Gyn and who had documented evidence of all of the following during the measurement year:

- BMI percentile
- Counseling for nutrition
- Counseling for physical activity.

Be sure to enter this information in patients' records.

Resources

When discussing exercise, diet, and other lifestyle behaviors with your patients, please refer to the benefits and resources that we offer to them.❖

Benefit:	For details:
• Weight loss benefit of $150 per year • Annual fitness benefit	Visit **bluecrossma.com/member-central**; go to **Healthier Living**, then click on **Fitness and Weight Loss**.
Many of of our health plans offer nutritional counseling benefits	Please check member benefits and eligibility via one of our electronic technologies.

Body Mass Index HEDIS Scores for BCBSMA

Below are BCBSMA HEDIS rates compared to several benchmarks from NCQA's Quality Compass 2012. Please note that while BMI value is used for adults, BMI percentile is required in medical records for the Weight Assessment and Counseling measure for children and adolescents because BMI norms for youth vary with age and gender.❖

	BCBSMA	Nat'l Avg	New Eng. Avg	State (MA) Avg	90th Percentile
Adult BMI Assessment	70.89%	55.41%	58.50%	76.44%	82.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile	82.49%	44.73%	59.09%	83.60%	82.97%
Counseling for Nutrition	79.38%	46.36%	64.09%	83.99%	76.40%
Counseling for Physical Activity	76.55%	43.00%	59.39%	79.71%	72.75%

Source: NCQA Quality Compass 2012

Physician News

Ambulatory Care Quality Reports for PCPs Are Available Online

As part of our commitment to support primary care providers (PCPs), BCBSMA has made available Ambulatory Care Quality Reports to help PCPs care for their patients. We hope you find these reports useful in helping to identify, contact, and remind your patients who could benefit from guideline-recommended preventive or chronic care screenings.

These reports focus on a wide range of NCQA HEDIS ambulatory care measures that evidence shows are important to the health of your patients and that are used for the Massachusetts Health Quality Partners (MHQP) practice-level results. The BCBSMA reports include:

- A year-to-date summary of your performance on each of the ambulatory care measures for which you have BCBSMA members, and
- For each measure, a list of the BCBSMA members in the measure population; whether they have the required screening; and the date, diagnosis, and procedure associated with the screening.

These reports are for PCPs in incentive programs other than the AQC and for measures for which PCPs have a sufficient patient population to be evaluated. The reports, now available online, include the following dates of service: January 1, 2012 – August 31, 2012.

To access your report, log on to **bluecrossma.com/provider** and click on **Manage Your Business> Access Your Reports**. We expect that you will use and protect the data in all of these reports in accordance with the same standards of privacy and confidentiality that you apply to all protected health information.

Your feedback is important to us, so please contact your Network Manager at **1-800-316-BLUE (2583)** with any questions related to these reports.❖

Refer Members to Preferred Providers for Insulin Pumps and Continuous Glucose Monitoring

November is National Diabetes Month and an opportunity to raise awareness of this life-threatening illness that affects more than 26 million Americans—over 8% of our population.

It's estimated that by 2050, as many as 33% of adults in the United States will have diabetes. This has a significant impact on health care costs, which, for a diabetic, are double that of an average, healthy person. In 2007 alone, the total cost to the United States was $218 billion, when factoring in the costs of undiagnosed diabetes, pre-diabetes, and gestational diabetes.

Helping Members Access Equipment and Supplies

We are committed to helping our members with diabetes access insulin pumps and glucose monitoring devices at an affordable cost. Through the Blue Cross Blue Shield Association, we are able to take advantage of preferred arrangements with the three insulin pump providers listed below to help our members save money. When writing insulin pump prescriptions for your patients—our members—please direct them to these preferred providers.

Medtronic to Use New Manufacturer for Blood Glucose Meters

Medtronic recently announced that it is phasing out use of the Johnson & Johnson One Touch meter along with its insulin pumps or continuous blood glucose monitors. They will now use Bayer's Contour®˝ Next Link wireless blood glucose meter, which is non-covered on our formulary. Our members can continue to use their One Touch meters and get their supplies from one of the preferred providers listed below.❖

Preferred insulin pump provider:	Website:	Phone number:
Animas	**animas.com**	**1-877-937-7867**
Better Living Now	**betterlivingnow.com**	**1-888-598-2365**
Edgepark	**edgepark.com**	**1-800-321-0591**

Are You Screening Your Older Adult Patients for Osteoporosis?

Each year, more than two million people in the United States experience a fragility fracture as a result of osteoporosis, generating an annual cost of $19 billion. The good news is that it is never too late to diagnose and treat osteoporosis.

"There's this notion that older patients don't need treatment, but those are the people who really need it," says Dr. Richard M. Dell, an orthopedic surgeon at Kaiser Permanente.

Screening and Treatment

It is important to screen patients for osteoporosis, especially after they suffer a fracture. The U.S. Preventive Services Task Force recommends that women 65 years of age and older receive osteoporosis screening every two years.

It is also recommended that if a patient has suffered a fracture, they should be screened with a bone mineral density (BMD) test within six months of the fracture. BMD testing (both densitometry and ultrasound) is covered by our Medicare Advantage products for diagnosing and treating the condition.

HEDIS Scores

The chart to the right shows the Centers for Medicare & Medicaid Services' HMO HEDIS scores for women 67 years of age and older who suffered a fracture, and who subsequently had either a BMD test or were prescribed a drug to treat or prevent osteoporosis in the six months after the fracture. This data is provided by NCQA Quality Compass 2011.

Osteoporosis Management in Women Who Had a Fracture	BCBSMA	90th Percentile
	22.07%	29.82%

Why Is There a Gap in Care?

According to Dr Dell, one reason for the gap in care evident in the scores above is that there is sometimes a miscommunication between PCPs and orthopedists.

"The orthopedist sees the patients and doesn't initiate treatment because they think the PCP will do it," he says. "The PCP doesn't initiate treatment because they think the orthopedist will take care of it."

To help manage gaps in care, organizations across the United States, United Kingdom, and Canada are implementing programs to focus on osteoporosis screening. Kaiser Permanente Southern California developed the Healthy Bones Model of Care program to proactively identify, screen, and treat those with, or at risk for, osteoporosis. The goal is to reduce the risk of costly, debilitating fractures.❖

To learn more, go to **innovations.ahrq.gov** and type **Healthy Bones Model of Care** in the search box.

Hypertensive Diabetic Patient Drug Therapy Reports Released

CMS has implemented performance and quality measures for Medicare health plans focused on improving quality of care and promoting the safe use of medications to improve patient outcomes.

To support this effort, beginning in August, select physicians received a letter from our pharmacy benefit manager, Express Scripts, Inc., with a list of patients in their practice diagnosed as hypertensive diabetics who may benefit from a change in medication therapy.

The goal is to help you understand the patients' utilization of high-risk medications, identify diabetic patients who are not currently on a cholesterol lowering statin, and identify hypertensive diabetics not currently on ACE/ARB therapy.

BCBSMA is committed to working with our physicians to promote clinically appropriate, cost-effective drug therapy for our Medicare members. We hope this patient list provides useful information, and we appreciate your shared dedication in our efforts to ensure the highest quality of care for our members.❖

Pharmacy Update

Important Pharmacy Updates for 2013

To offer our members a more affordable pharmacy benefit, we are making these changes to our pharmacy program:

- Requiring prior authorization for certain medications that are administered in a clinician's office or outpatient setting, or by a home infusion therapy provider, and that are billed under the member's medical benefits. We are updating existing medical policies to reflect the new requirements.
- Updating our standard formularies and our BlueValue Rx, Blue MedicareRx, and Medicare Advantage formularies. These include tier changes, drugs moving to non-coverage, quality care dosing limits, and prior authorization requirements.
- Excluding from coverage all ophthalmic solutions used to treat allergies for all commercial members, Medex group members who have BCBSMA pharmacy coverage, and Managed Blue for Seniors℠ members.
- Excluding non-sedating antihistamines from coverage for our Medex group members who have BCBSMA pharmacy coverage and for Managed Blue for Seniors members. This benefit exclusion has been in place for members in our commercial products since 2009.
- Phasing out our BlueValue Rx formulary upon account anniversary; changes taking effect January 1, 2013 are applicable until the member transitions to the standard formulary.

For more details on these changes, including specific formulary changes, please view our *F.Y.I.* on BlueLinks for Providers.❖

To:	Log on to bluecrossma.com/provider and select:
Download medical policies and pharmacy medical policies	**Manage Your Business>Review Medical Policies> View Medical Policies**. You can view an alphabetical listing, search by category, or use the Quick Search feature.
View the *Outpatient Medical Prior Authorization Form*, to fax prior authorization requests for medications administered in your office or an outpatient setting	**Resource Center>Forms>Pharmacy Forms.**
View an updated *List of Medications That Require Prior Authorization When Administered in a Clinician's Office or Outpatient Setting*	**Manage Your Business>Search Pharmacy & Info>Drug Management Programs.**
View a list of standard, BlueValue Rx, Medicare Advantage, and Blue Medicare Rx formulary changes	**News for You>FYIs.** Scroll down to the *F.Y.I.* dated September 1, 2012 (PC-1494A). A PDF is displayed in the Resources section of the *F.Y.I.*

Help Combat Fraud: Be Sure to Respond to Prescription Verification Requests

Verifying the legitimacy of prescriptions plays a key role in CMS' efforts to combat fraud, waste, and abuse in the Medicare Part D program.

As part of the investigation process, CMS' National Benefit Integrity Medicare Drug Integrity Contractor (Health Integrity, LLC) routinely mails a prescription verification form to prescribers. The form contains the beneficiary's name, the name of the medication, the prescription date, and the quantity given. The form also asks the prescriber to check "yes" or "no" to indicate whether the prescriber wrote the prescription. The prescriber is asked to respond within two weeks.

If the prescriber does not respond, the investigator follows up with a second request.

If you receive a verification form, please complete it in a timely manner. Your response can help to confirm or eliminate an allegation of wrongdoing and prevent payments for fraudulent prescriptions.❖

Office Staff Notes

Announcing Medicare Product and Benefit Changes for 2013

BCBSMA will continue to provide a full array of Medicare solutions to our members next year, including more affordable options.

On January 1, 2013, we are:

- Introducing a new, more affordable, low-premium Medicare PPO direct-pay plan, called Medicare PPO Blue ValueRx, with a premium of $66.10. It has a five-tier pharmacy benefit and is based on the Medicare Advantage formulary.
- Significantly reducing premiums for our Medicare HMO Blue ValueRx plan, from $87 to $28.
- Improving the mail-order benefit for all Medicare Advantage plans. Members will be able to get a three-month supply for a covered prescription drug for a one-month copayment for all Tier 1 drugs at a network mail-order pharmacy.

We will publish more details on our BlueLinks for Provider website by December 1, and will share more updates in future issues of *Provider Focus*.❖

Reminder on BCBSMA's Filing Limit for PPO Claims

As a reminder, BCBSMA requires that providers submit accurate and complete claims for covered services rendered to PPO members within 90 days of the date of service.

To avoid exceeding the timely filing limit, be sure to compare your reports of submitted claims with your postings of payments or denials each month, and use our technologies to verify claims status to ensure your claim was received on time.

We encourage you to submit claims electronically; however, for CMS-1500 paper claims, coordination of benefits, and third-party liability, please mail to:

Blue Cross Blue Shield of MA
P.O. Box 986020
Boston, MA 02298

Please note that we may not honor claims submitted after the 90-day period.

To request a claim review, submit the *Request for Claim Review Form*, which is available on our website.

For more information, please refer to the "Guidelines for Claims Filing Limits" and "Timely Filing Exceptions" information in Section 3: Billing and Reimbursement of the *Blue Book* manual, also available on our website.

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

To:	Log on to bluecrossma.com/provider and select:
Access the *Request for Claim Review Form*	**Resource Center>Forms>Review and Appeals**
Access the *Blue Book* manual	**Resource Center>Admin Guidelines & Info>Blue Books**

Office Staff Notes

You Can Now E-mail Credentialing Documents to CAQH®

HealthCare Administrative Solutions (HCAS) has announced that CAQH now accepts supporting documents via e-mail.

You can can e-mail electronic copies of the *Authorization, Attestation and Release Form*, professional liability insurance policy face sheets, DEA certificates, and other supporting documents.

If you choose to e-mail documents to CAQH, you must use a specific cover sheet, available at **https://upd.caqh.org/OAS**.

Once logged on to the Online Application System, you can find the cover sheet by going to the Attachments tab. CAQH has updated the Attachment page with instructions on how to use this new feature.❖

What Health Care Technologies Do You Use?

The Massachusetts Division of Health Care Finance and Policy sets requirements for insurers to collect information about statewide provider technology use.

To streamline the collection process, HealthCare Administrative Solutions (HCAS) has released a *Provider Technology Adoption Survey*. We encourage you to complete the survey as soon as possible at **hcasma.org**. From the home page, click on the survey link.

Providers need to fill out the survey just once for all insurers who participate in HCAS.

Facilities and groups may submit survey responses on behalf of their providers. HCAS will submit information collected to the participating health plans and to the state.❖

Click & Connect Locked out of our BlueLinks for Providers Webiste?

If you're locked out of your BlueLinks account, there's no need to call our Help Desk. An **account administrator from your office** can reset your password quickly by simply going online.

To unlock your account, an administrator must go to **bluecrossma.com/provider** and:

- Sign in using their user name and password.
- Select **Manager Users** under Administration.
- Select the name of the locked out user to view their profile.
- Scroll to bottom of the page and click **Reset Password**.

A message will appear at the top of the page stating that a "Temporary password was emailed to user."

Want to Learn More?

If you have questions about using BlueLinks, please refer to our *User Guide* online.

From any page on BlueLinks, click on the **Help** link in the upper right-hand side of the screen. Then select **User Guide**.❖

Office Staff Notes

Submitting the Right Information for Individual Consideration Appeals Involving a "Not Otherwise Classified" (NOC) Code

If you submit an appeal for individual consideration of a "not otherwise classified" (NOC) code, be sure to include all reports that document the service rendered (e.g., the operative report) along with a **detailed description of NOC services performed**. Please do not submit the entire medical record.

Enter the detailed description of the NOC service in the comment section of the *Request for Claim Review Form* (see instructions below for accessing this form on our website). This will help to expedite your appeal. Please include an invoice, if applicable.

For more information on appeals, please refer to Section 4: Reviews, Appeals, and Audits of your *Blue Book* manual.

Or, if you have questions, please call **1-800-882-2060**.❖

To:	Follow these instructions:
Download the *Request for Claim Review Form*	Log on to **bluecrossma.com/provider** and click on **Resource Center> Forms**. Then scroll down to the Review and Appeals section.
Find "Section 4: Reviews, Appeals, and Audits" of our *Blue Book*	Log on to **bluecrossma.com/provider** and click on **Resource Center> Admin Guidelines & Info>Blue Books**.
Submit an appeal for individual consideration	Mail to: Blue Cross Blue Shield of MA Provider Appeals P.O. Box 986065 Boston, MA 02298

Sample Request for Claim Review Form

☐	**Referral Denial:** The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.	
☐	**Request for additional information:** The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC Codes, Home Infusion Therapy).	
☐	**Retraction of Payment:** The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).	
☒	**Other:**	**NOC service is an 'Arthroscopic biceps tenotomy'**
Comments *(Please print clearly below)*:		

When your individual consideration appeal involves a NOC code, be sure to include a description in the Comments section of the *Request for Claim Review Form*, in addition to reports that document the service rendered (i.e., operative report).

Office Staff Notes

How to Submit Address and Telephone Number Changes to Us

Having accurate address and telephone information for BCBSMA providers is important so that we can provide the most up-to-date information to our members through our provider directories.

If you are currently contracted with BCBSMA as an individual provider and you are updating your primary site or billing address, or telephone number, you must:

- Update your recredentialing application through the CAQH website at **caqh.org**, and
- Submit a *Change of Address Form* to our Provider Enrollment area.

For the Primary Telephone Number, please indicate the number your patients would call to schedule an appointment.

All changes must be submitted to us in writing.

Important: Please complete a *Contract Update Form* if you are affiliated with a group and you are:

- Leaving a group practice/ location
- Joining a different group
- Adding a secondary site.

To access either the *Change of Address Form* or *Contract Update Form*, log on to our website at **bluecrossma.com/provider** and click on **Resource Center> Forms>Administrative Forms**.

Then select the appropriate form for your provider type. Be sure to complete all fields on the form and fax it to us at the number listed on the form. Please do not use the CMS-1500 claim form or the CAQH recredentialing application to notify us of address changes.❖

Billing Notes

Upcoming Medical Record Audits Will Focus on the Use of Modifiers

If you currently use modifiers in your billing, it is important that you are using them correctly. Modifiers indicate that a service or procedure you've performed has been altered by some specific circumstance, but has not changed in its definition or code.

Over the next several months, BCBSMA will be conducting audits to verify the appropriate use of modifiers 25 and 59—two modifiers that are frequently billed incorrectly. We will communicate details of the audit plan with providers as they are finalized.

As a reminder, we expect that when you submit claims with modifiers 25 or 59, you always have documentation available in the patient's record to support the distinct or independent identifiable nature of the service submitted with these modifiers.

Please note: all claims submitted with modifiers 25 and 59 are subject to **pre- and post-pay** audit by BCBSMA.❖

Modifier 52 Update Will Go into Effect January 1, 2013

Effective January 1, 2013, BCBSMA will recognize the use of modifier 52 on additional CPT and HCPCS codes. CPT and HCPCS codes submitted with modifier 52 appended are generally paid at 50% of the contracted rate.

Modifier 52 is used when a provider has elected to reduce or eliminate a portion of a service or procedure.

It is not necessary to submit additional documentation with these claims.❖

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 Cancers: When to Code as an Active Cancer

This Coding Corner article is Part 2 of an article published in September Provider Focus: "Coding Active Cancer versus a History of Cancer."

Documenting and coding for care delivered to patients with cancer can present a challenge to both health providers and coding staff. To accurately code a cancer diagnosis, it is important that the medical documentation clearly states if the cancer is a current, active condition ***or*** a past condition that has been excised or eradicated with no further treatment.

In the September 2012 issue of *Provider Focus*, we addressed cancers that have been excised or eradicated with no further treatment and no evidence of a recurrence. Per *ICD-9-CM Official Guidelines for Coding and Reporting*, "history of cancer" should be reported with a **V10 code: personal history of malignant neoplasm**.

To code as an active cancer using ICD-9-CM codes **140-239** (according to the ICD-9-CM Neoplasm chapter), the cancer must be currently present ***or*** under treatment (e.g., surgery, chemotherapy, radiation therapy, hormone therapy).

The examples below show when it's appropriate to report the cancer as an **active cancer** using ICD-9-CM codes **140-239** (according to the ICD-9-CM Neoplasm chapter), even when your patient has had surgery and/or radiation and has no evidence of active disease or recurrence, but is still under active management of the disease with adjuvant hormonal therapy.❖

About Office Notes

When coding the office note, ask these important questions to help determine the correct code:

- Is the cancer a current, active condition or a past condition?
- Has the cancer been excised or eradicated?
- Is the cancer still under treatment?
- Is there any evidence of recurrence?

The office note should clearly state:

- If the cancer is present or has been excised or eradicated
- Current treatment
- Evidence of cancer recurrence.❖

Example 1

The office note states the patient had a malignant breast cancer excised six months ago and was started on tamoxifen as adjunctive hormonal treatment of the breast cancer. There is no evidence of active disease. The correct code assignment would be the appropriate breast cancer code from category **174** along with code **V58.69: long-term (current) use of other medications**. The cancer is still under treatment and can be coded as an active cancer, according to *Coding Clinic*, Fourth Quarter 2008. This guidance would apply to any drug used as adjunctive treatment of the cancer after surgery.

Example 2

The office note states the patient completed a course of radiation therapy for prostate cancer and has no evidence of active disease; however the patient continues with long-term hormone therapy as part of the cancer management. The correct code assignment would be **185: malignant neoplasm of prostate**, along with code **V58.69: long-term (current) use of other medications**. As in the example above, the cancer is still under treatment and can be coded as an active cancer.

Medical Policy Update

Medical Policy Announcements for January and February 2013

A large number of new BCBSMA medical policies and medical policy revisions will take effect in January and February 2013. Rather than posting the updates in this issue of *Provider Focus*, will post a fully searchable list of revised policies on our website on October 1, 2012. This will help to make it easier for you to find the policies and revisions that are of interest to you.

To find the list on or after October 1, go to **bluecrossma.com/medicalpolicies** and click on the link on the right-hand side of the page. The list will be organized alphabetically by policy title. By clicking on the policy title within this document, you will be directed to its entry in a summary table. See sample below.

Policy Drafts Are Available upon Request

Full draft versions of each policy are available by request one month prior to the effective date of the policy. For example, policies with an effective date of January 1, 2013 can be requested on December 1, 2012; policies with an effective date of February 1, 2013 can be requested on January 1, 2013. To request draft policies, e-mail Medical Policy Administration at **ebr@bcbsma.com**.

Reminder: New 2013 Category III CPT Codes

All category III CPT codes are non-covered unless they are explicitly described as "medically necessary" in a BCBSMA medical policy.

To search for a particular code online, go to **bluecrossma.com/medicalpolicies** and type the code in the search box. Consult the coverage statement of any associated medical policy. If there is no associated policy, the new code is non-covered.❖

Sample Format for Medical Policy Updates Available on Our Website as of October 1, 2012

Medical policy title:	Policy number	Policy action:	Products affected:	Effective date:
Chromoendoscopy as an Adjunct to Colonoscopy	8XX	New medical policy: Investigational indications described	▸ Commercial ▸ Medicare	January 1, 2013

Medical Policy Documents Will Have a New Look in 2013

Starting in February 2013, BCBSMA will unveil reformatted versions of our medical policies. These new policies will be reorganized and rewritten to make them easier to use and understand. In addition, longer, more complex policies will be separated into single-topic medical policy documents.

Our goal is to simplify the way we present information to you and ensure that all of our medical policies follow a consistent format.

We will provide you with more details about the changes in the December issue of *Provider Focus*.

In early December, a sample medical policy will be available on the Medical Policy page of our BlueLinks for Providers website, **bluecrossma.com/provider**. If you have any questions now or after reviewing the policy, please contact us at **ebr@bcbsma.com**.

Please note that current policy coverage statements will remain the same in the new documents. If we do have revisions or changes to any medical policy coverage statements, we will continue to communicate them in *Provider Focus* or on the medical policy website 90 days prior to the effective date.❖

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

Landmark Center
401 Park Drive
Boston, MA 02215

Providerfocus

ROUTING BOX
Date received:_____
Please route to:
- ☐ **Office manager**
- ☐ **Physician**
- ☐ **Nurse**
- ☐ **Billing manager**
- ☐ **Billing agency**
- ☐ **Receptionist**
- ☐ **Other:** _____

Questions about billing for the flu vaccine?
Log on to **bluecrossma.com/provider** and click on the **Flu** link.

At Your Service

- BlueLinks for Providers
  www.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:

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