Beyond Patient Satisfaction: Patient-Centered Care Improves Health Outcomes

Patient-centered care has become an important health care buzz word since the Institute of Medicine (IOM) named it as one of six fundamental aims of the U.S. health care system in its 2001 report, Crossing the Quality Chasm.

However, the true meaning and value of patient-centered care may have become diluted with its frequent repetition. More than just a movement to improve patient satisfaction, patient-centered care improves patient health quality and outcomes, and can also reduce health care costs.

With patient-centered care, there is a partnership among providers, patients, and their families, which is particularly important for patients with chronic, serious, or complex conditions. Decisions are respectful of patients’ individual needs, circumstances, and preferences.

Perhaps most importantly, the care process is designed to provide patients with the information and support they need to participate in treatment decisions and to effectively manage their condition in their daily lives.

Proven Outcomes

“Improved adherence to clinical advice is perhaps one of the most important advantages associated with patient-centered care,” says Dana Gelb Safran, Sc.D., Vice President, Performance Measurement & Improvement for BCBSMA. “This is not a model about improved customer service or nicer waiting rooms. It’s about using the clinical encounter as a critical teaching opportunity—and a one-shot chance to meaningfully address the issues, concerns, and questions that could stand in the way of patients following their doctor’s advice when they walk out the door.”

This style of care is not new, and it is central to what physicians and other clinicians aim to achieve for their patients. But the complexity and pace of care these days can make this challenging. Despite this challenge, efforts to achieve more patient-centered practices have been shown to be successful. And the benefits accrue not just to patients, but to the clinicians—who report feeling more professionally satisfied when their practices encourage and reward this relational dimension of care.

continued on page 10

In Brief

Your 2008 Blue Book Is Now Available Online

We’re pleased to announce that the 2008 BCBSMA Blue Book for professional providers is now available online.

Log on to our website at www.bluecrossmassma.com/provider and click Resource Center>Admin Guidelines & Info>Blue Books. Our online version makes it easy for you to quickly access and print the sections you need to help with your BCBSMA administrative tasks.
BCBSMA Launches Disease Management Program for Members With Asthma

To help our members with asthma manage their health, BCBSMA has expanded our Blue Care Connection® program to include asthma disease management. Our Blue Care Connection programs seek to support providers and help members to receive evidence-based care appropriate for their condition and improve members’ quality of life.

BCBSMA identifies members for this program through medical claims and other health care data. Physicians may also refer their patients to the program. The program is voluntary; members may choose whether or not to enroll and may opt out at any time. Members are periodically categorized as either high- or low-risk using predictive modeling methodology and are targeted to receive appropriate interventions. Participants identified as high-risk will receive:

- Initial outreach and assessments by telephone
- Scheduled calls to provide education, set and monitor self care goals, and reassess health care needs
- Depression screening and support to enhance coping skills, lifestyle management, and quality of life
- Mailings that include education, action plans, and reminders about standards of care as well as the member’s agreed upon self-care goals.

Members stay in the program until they have been categorized as low-risk for one year, but may re-enroll if their status changes. Those identified as low-risk receive educational mailings, including self-management tools, reminders about standards of care, and newsletters.

Our Blue Care Connection programs are designed to help educate our members, and support the physician-patient relationship and plan of care.

To refer a member, log on to www.bluecrossma.com/provider, and select Resource Center>Forms>Practice Management Tools.

Questions?
- Blue Care Connection: 1-877-301-1430
- BCBSMA Clinical Coordination: 1-800-392-0098
- Provider Relations: 1-800-316-BLUE (2583).

From the Chief Physician Executive

Dear Providers:

By logging on to our website at www.bluecrossma.com/provider, you can:

- Read my current and previous letters (with associated links to helpful resources) on important topics in health care today
- E-mail your comments on any of the letters through this link.

I welcome your input.

Sincerely,

John A. Fallon, M.D.
Chief Physician Executive
Senior Vice President
john.fallon@bcbsma.com

BCBSMA Phases Out Depression Disease Management Program

Effective January 31, 2008, we will phase out our depression disease management program and transition eligible participants to our Case Management Program, as appropriate. We plan to study how to better serve our members with major depression through new and existing programs, and will update you of these plans as they develop.

See our new section for Behavioral Health providers, pages 4-6
**Improve Health Literacy Can Help to Improve Patient Care**

The American Medical Association (AMA) reports that 90 million people in the United States struggle with health literacy. Inadequate health literacy affects all segments of the population, but is more common among the elderly, the poor, members of minority groups, and recent U.S. immigrants. Patients with low health literacy may hide their misunderstanding, which can lead to:

- Misinterpretation of health care instructions, prescriptions, and follow-up plans
- Poorer health outcomes
- Medical errors
- Increased medical costs.

Patients—even those with adequate literacy skills—may hide their confusion from doctors because they are ashamed or intimidated. To better communicate with your patients, the AMA suggests you:

- Use plain, non-medical language
- Slow down and break it down; use short statements.
- Organize information into two or three concepts, then check for understanding.
- Ask patients to repeat back what they were told. Ensure they understand by asking them to restate in their own words what they need to know or do.
- Create a shame-free environment.

**Red Flags**

Warning signs of low health literacy may include:

- Incomplete registration forms or health questionnaires
- Repeated medication mistakes
- Lack of follow-through with laboratory tests or referrals
- Excuses that patients forgot their glasses or complaints about small print
- Tendency to describe medications by color or shape, rather than by name.

**Resources**

- AMA Foundation: [www.amafoundation.org](http://www.amafoundation.org)
- Institute of Medicine of the National Academies: [http://www.iom.edu](http://www.iom.edu)


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**Pharmacy Update**

**BCBSMA Has New Phone-Based Process for Pharmacy Prior Authorizations**

Based on feedback from our provider satisfaction surveys, BCBSMA now enables providers to request pharmacy prior authorizations over the phone in addition to the current fax-based process. Just call 1-800-366-7778 between 8 a.m. and 6 p.m. and follow the voice prompts. The new process reduces the time it takes for a member to have access to medications that require prior authorization, and gives you immediate feedback about whether the authorization has been approved or denied.

**Non-sedating Antihistamines to be Excluded in 2009**

Coverage is being modified in a two-step process. First, as of January 1, 2008, all forms of Allegra® and fexofenadine were moved to our non-covered drug list. You may request a formulary exception for the medication, but will need to provide documentation demonstrating the use of an over-the-counter alternative.

Second, because of the availability of over-the-counter non-sedating antihistamines, including the forthcoming availability of Zyrtec®, BCBSMA will exclude all non-sedating antihistamines from coverage on January 1, 2009. At that time, formulary exceptions will no longer be available. We have begun notifying accounts of this change and want physicians to be aware as well. Members who are taking a non-sedating antihistamine through a formulary exception will be notified via letter by November 1, 2008. This change does not affect members of Medex®, Medicare Advantage, Managed Blue for Seniors, and non-group Indemnity plans.
Behavioral Health Highlights

Treatment Outcomes Package Can Help You Deliver Better Quality Care

This is the first in a series of articles planned to highlight how clinicians can take advantage of the Behavioral Health Outcomes Measurement Program to improve clinical outcomes in their practice.

BCBSMA has undertaken the Behavioral Health Outcomes Measurement Program to address one of the specific gaps in care—measurement—which was identified by the Institute of Medicine (IOM) in Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. BCBSMA is enthusiastic about the ability of this process to enhance care and to spotlight the crucial role of behavioral health care and behavioral health providers in an integrated care delivery system.

As we near the end of the first six months of operation, providers who are using the tool for initial and subsequent patient evaluations tell us that they are seeing benefits in treatment effectiveness; and we have had positive feedback on the steps BCBSMA has taken to protect the confidentiality of the instrument answers and scores. Published evidence of the positive impact of provider outcomes measurement continues to accumulate, and additional health plans have adopted, or are planning to adopt, an outcomes measurement strategy.

We are pursuing a dialogue with providers on the use of outcomes measurement in clinical care to guide the evolution of our system, and we have already made several changes to the program based on provider feedback.

Repeat Administrations Help Providers Track Patient Progress

In using the Treatment Outcomes Package (TOP), it is important to consider repeat administrations of the instrument to track progress occurring in treatment, and to identify those not responding optimally to care. The TOP is designed to be sensitive to change across its full range of measurement (e.g., avoiding floor and ceiling effects which limit utility in patients with mild or very severe symptoms), and can be effective in augmenting your clinical assessment of the patient’s progress. Some variability from administration to administration should be expected; however, over time, you and your patient should see measurable progress in the domains targeted by your treatment plan.

If progress is not evident on repeat administration, you may want to consider identifying specific barriers standing in the way of improvement with your patient.

Some providers have commented on the appearance of unexpected levels of symptom severity or dysfunction when comparing what is verbally reported by the patient and what is elicited by the TOP. These can arise for several reasons, including the patient withholding information from the provider, or the patient minimizing or exaggerating survey responses on the instrument itself.

Whatever the reason for the disparity, valuable therapeutic work may be accomplished by exploring the source of the discrepancy. Because the TOP is a multi-dimensional instrument, it may also help you to identify other symptoms or function areas for attention which the patient may not have emphasized verbally during your assessment.

Our Commitment to Partnering With Behavioral Health Providers

BCBSMA recognizes that the TOP administration process adds time to the therapy process, but we strongly believe that it provides helpful information for both the therapist and the patient, especially for patients who aren’t responding optimally to treatment.

BCBSMA is committed to collaborating with providers to minimize the challenges of administering the TOP, and we are working with the Massachusetts professional societies and the provider community to make the process more efficient.

Our goal is to assist providers in delivering the best quality care, and to support the high aspirations of the IOM report.

See page 2 for important information about our depression disease management program
Quick Tips for the Behavioral Health Outcomes Measurement Program

We have developed some quick tips to help you improve your interactions with the Behavioral Health Outcomes Measurement program. If you have any questions about these tips, please call Behavioral Health Laboratories (BHL) at 1-800-329-0949.

Reducing Administrative Time

- Only the first administration requires submission of all three Treatment Outcomes Package (TOP) forms: Consumer Registration (CR), Case-Mix (CM), and Clinical Scales (CS). Prior to the start of each day, you may wish to create TOP packets for each scheduled client who is eligible for the first administration. Complete the “for office use only” fields in advance. On the back of each of the CR forms, write your patient’s name. This will enable you to connect the BHL number and patient’s BCBSMA ID on the front with your patient.

Speeding the Authorization Process

- If you receive a client report with “Error! Call BHL!” at the top left corner, contact BHL to fix the problem. This message is usually caused by one of the following:
  - Member ID errors
  - Missing or incomplete DOB
  - Missing diagnosis when authorization is requested.

- If you see the BCBSMA logo in the top left corner of the client report, it indicates that the transmission was successful and the authorization request will be transmitted to BCBSMA.

- If you are using the TOP to request authorizations, be sure to enter a number of sessions in the Payer Request Field of the CS form. To correct forms that have previously been submitted without completing the Payer Request Field, contact BHL and inform them that you want to update that field. Once you do so, a request to BCBSMA will be generated.

Determining Eligibility for the Treatment Outcomes Package Based on the Member’s Plan

Are you having trouble figuring out which BCBSMA members are eligible for the Treatment Outcomes Package (TOP) administration?

We now have a chart on our BlueLinks for Providers website to help you determine eligibility based on the member’s plan. To find the chart, log on to www.bluecrossma.com/provider, click on the Outcomes Measurement Program box on the right-hand side of the page, and select How to Determine Which Patients are Eligible for the TOP.
BCBSMA’s Behavioral Health Case Management program assists providers and their patients who are at risk for hospitalization or who are having difficulty making expected progress in outpatient treatment. Our experienced team of licensed clinical social workers and psychiatric nurse clinicians will consult by telephone with you and offer your patient resources to support your plan of care. You can refer to this program patients who have:

- A history of psychiatric or substance abuse hospitalizations, or are at risk for a first admission—the key requirement for referral to Behavioral Health Case Management
- Chronic psychiatric diagnoses and are at risk for treatment failure or drop-out due to medication noncompliance, barriers to attending treatment, or low motivation/ambivalence
- Difficulty managing chronic medical conditions or lifestyle problems that impact their overall behavioral health.

**How To Refer a Patient**

- Log on to our website at [www.bluecrossma.com](http://www.bluecrossma.com/)
- Click Resource Centers>Forms>Practice Management Tools, and select the Patient Referral for Case Management Form. Complete the form and fax to the number indicated on the form. We will contact you by phone and discuss the referral.
- Or, call the Behavioral Health number on the member’s ID card. Ask for a new Behavioral Health case management referral, or leave a message.

**Benefits for Providers Include:**

- Suggestions for services to complement your outpatient care during a time of crisis (e.g., intensive outpatient or partial hospital programs or family stabilization services)
- Help referring your patients with chronic medical problems that impede psychotherapy progress to disease management, health coach, and prevention and wellness programs
- Help referring your patients to other behavioral or medical specialty providers.

**Benefits for Patients Include:**

- Assistance with referrals to other types of providers, self-help, and wellness groups
- Help with coordination of benefits between behavioral health and medical specialists
- Guidance on benefit questions
- Educational materials or medication management
- Suggestions for Web-based educational and self-help behavioral health resources.

**Using the Treatment Outcome Package for Case Management**

You may find the Behavioral Health Laboratories Treatment Outcome Package (TOP) helpful in identifying and referring eligible patients to our Behavioral Health Case Management program. The key referral criteria is a high risk of inpatient hospitalization for psychiatric or substance abuse disorders, which may be indicated on the TOP by:

- Severe psychosocial stressors and barriers to treatment that your patient reports on the Case-mix form
- Significant co-morbid medical problems that interfere with treatment progress that your reports on the Case-mix form
- Evidence of lack of progress or worsening of condition (for example, lack of progress or worsening of subscales such as Depression, Substance Abuse, and Psychosis) based on re-administrations of the Clinical Scales.

Clinical research has shown that acting on feedback from patients who are not making good progress in therapy may significantly improve outcomes and quality of care. We hope that you will find the TOP clinically useful as a tool to trigger referrals of some patients to Case Management.
The NPI compliance deadline of May 23, 2008 is fast approaching. Consistent with the Centers for Medicare & Medicaid Services (CMS), beginning March 1, 2008, BCBSMA will reject all electronic transactions submitted with only the legacy provider number. Here we summarize requirements for specific transactions for the period March 1, 2008 through May 22, 2008.

To ensure a smooth transition to NPI-only transactions, you should begin using your NPI as soon as possible for all of the transactions listed in the table to the right.

Please advise all personnel performing the transactions listed in this article to begin using their NPI as soon as possible. In addition, and if applicable, please share this information with your IT area to ensure that all automatically generated transactions have been updated with NPI information as well. All vendors, clearinghouses, and billing agencies should have your NPIs and use them when conducting business on your behalf with BCBSMA.

*About Claims Submissions
BCBSMA will continue to accept dual-use claims submitted with both the NPI and your BCBSMA legacy provider number through May 22, 2008—the end of the contingency period established by CMS.

Effective May 23, 2008, BCBSMA will no longer accept claims with a legacy number, including dual-use formatted claims.

If you do not use your NPI by the CMS mandated deadline of May 23, 2008, dropping your claims to paper will not keep them from rejecting. BCBSMA will reject paper claims submitted without an NPI beginning May 23, 2008. (Ancillary providers: please see page 11 for important information about your NPI.)

Report All NPIs to BCBSMA Now
Your NPI must be on file with BCBSMA. If you have not already done so, please submit your NPI information by logging on to www.bluecrossmasa.com/npicollection or by calling us at our dedicated toll-free NPI number 1-888-781-1309.

If you attempt to use your NPI and receive an error message stating “Invalid/Missing Provider Identification” or “Entity’s Blue Cross Provider ID”, please call us at 1-888-781-1309 so that we may update our files with your NPI.

Once you have shared your NPI with us, please allow three business days for us to update our systems. With your NPI on file, BCBSMA will cross-walk your proprietary/legacy number(s) to the corresponding NPI. If you previously submitted a claim or a referral/authorization under your legacy number, you may inquire about it using your corresponding NPI.

Attention Emdeon Office and BlueLinks for Providers Administrators
To ensure that NPI information is made available to you and your office staff when performing any of these interactive transactions, please update your Office Group Favorites list with any applicable NPIs. Step-by-step instructions have been posted to the Emdeon Office and BlueLinks for Provider Online Services flash message segment (located on the technology’s home page). If you or your staff use both systems, each system will require its own update. If you need help in determining how to complete the updating of the Group or My Favorites listing, please call Emdeon at 1-800-266-2206, Option 7.

Attention Ancillary Providers: See page 11 for an important message about your NPI.
When a patient has more than one insurer covering his or her health care costs, it’s important to coordinate benefits to avoid claim rejections.

To help you gather COB information for a BCBSMA member, you can now download our *Coordination of Benefits Questionnaire* from our website at [www.bluecrossma.com/provider](http://www.bluecrossma.com/provider). Log on and click Resource Center>Forms>Reviews and Appeals.

Ask the BCBSMA member to fill it out and return it to the BCBS plan to which they belong. That plan should update their membership files within five business days of receiving the form.

For more information about COB claims, refer to “Coordinating Benefits” in the Billing and Reimbursement section of your Blue Book manual.

To access any of our training programs, log on to our website at [www.bluecrossma.com/provider](http://www.bluecrossma.com/provider) and select Resource Center>Training & Registration.

*NEHENNet is a collaboration of BCBSMA, Harvard Pilgrim Health Care, Tufts Health Plan, BMC HealthNet Plan, Health New England, and Neighborhood Health Plan.*

**New Resources Are Now Available on our BlueLinks for Providers Website**

BCBSMA is pleased to feature the following new training courses online:

- Blue Fundamentals: Credentialing through HCAS (available February 15)
- Electronic Technology Overview (updated with NEHENNet information).

Interested? Call NEHENNet at 781-290-1290.

NEHENNet: New Functionality Available Via Single WebSite for Many Payers

BCBSMA now offers new, expanded functionality to providers through NEHENNet*, the multi-payer portal offered to providers with the New England Healthcare EDI Network (NEHEN).

For a small, fixed monthly fee, registered NEHENet users can now perform these functions for more than five million health plan members from six local health plans:

- Check eligibility
- Submit claims via batch
- Request and inquire about referrals and authorizations
- Check claim status
- View remittances with multiple payers.

Interested? Call NEHENNet at 781-290-1290.

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*NEHENNet is a collaboration of BCBSMA, Harvard Pilgrim Health Care, Tufts Health Plan, BMC HealthNet Plan, Health New England, and Neighborhood Health Plan.*
BCBSMA has an agreement with six Health & Welfare Funds (unions) under a program called Union Blue. It is a shared partnership between BCBSMA and these six specific funds.

The Union Blue fund plans have unique coverage and benefit structures. Because there are more than 73,000 members participating in these plans, you are likely to see some of these members in your office.

The following information clarifies who to contact with questions about Union Blue.

- Please check Union Blue members’ benefits and eligibility via one of BCBSMA’s electronic technologies (Online Services, Emdeon Office, etc.) If you are unable to obtain information via technology, call our Provider Services Department (professional providers: 1-800-882-2060; ancillary providers: 1-800-441-8124).

- As with all other BCBSMA members, confirm eligibility and benefits prior to rendering services. You will recognize the Union Blue card by the fund logo in the top, right corner. The six Union Blue funds are listed in the table above.

- As always, if a member of Union Blue or any other BCBSMA plan has questions about their benefits, please direct them to the customer service number printed on the member ID card. This number is for member information only. Providers should always use our technologies, or call the BCBSMA Provider Services Department for information that is not available via our technologies.

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<td>Massachusetts Bricklayers &amp; Masons Trust</td>
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<td>Massachusetts Laborers Health and Welfare Funds</td>
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Chart Review Reminder: Ensure All Documentation Includes a Signature

As you may know, some providers with patients who are members of BCBSMA’s Medicare HMO Blue® and Medicare PPO Blue℠ health plans are being asked to take part in a data collection process to identify all documented and appropriate ICD-9-CM codes.

This chart review process is required by the Centers for Medicare & Medicaid Services (CMS) to accurately reflect the health status of all beneficiaries.

Feedback so far from Leprechaun™ HCC Management Outsourcing, the health care consulting service that is assisting us in this process, has shown that signatures are missing from some documents.

BCBSMA reminds you that for medical review purposes, CMS requires a legible provider signature on all medical record documentation, including orders. The signature method used may be handwritten or electronic.

If you have any questions, please contact your Provider Relations representative at 1-800-316-BLUE (2583).
Use of Modifier 22 When Billing Complex Surgical Procedures

When submitting claims that include an unusually difficult procedural service or “Increased Procedural Services,” add Modifier 22 to the appropriate CPT® code. Modifier 22 is used to report the need for a level of work far greater than that usually required to complete the procedure. Based on the use of the modifier, notes will be submitted, and the case will be reviewed to determine if additional reimbursement is warranted for the procedure.

Additional work during a surgical procedure may be necessitated by the presence of a significantly altered surgical field, excessive blood loss, extensive trauma that complicates the procedure, other pathologies that interfere with the procedure, an unusually large surgical specimen or any other documented complication that makes the procedure unusual or lengthy.

Effective April 1, 2008, additional reimbursement will only be considered if the additional work is documented in the Operative Report submitted to support the use of Modifier 22. Descriptions of additional work included in a cover letter are not considered part of the medical record and cannot be used to support additional reimbursement. You may or may not receive additional reimbursement when the claim is paid based on the information in the Operative Report.

To appeal a decision, please follow the procedures described in the “Reviews and Appeals” section of your Blue Book manual, which is available online. Log on to www.bluecrossma.com/provider and click Resource Center> Admin Guidelines & Info>Blue Books.

If you have questions about this policy or about individual consideration, please contact you Provider Relations Manager at 1-800-316-BLUE (2583).™

Beyond Patient Satisfaction: Patient-Centered Care Improves Health Outcomes

continued from page 1

Academic research leading up to the release of the IOM report has linked patient-centered care to both health outcomes—like adherence—and to favorable business outcomes, including reduced malpractice risk. In one randomized trial of diabetes patients, the intervention group received physician coaching on care regimens and lifestyle changes, while the control group did not. Not only did the intervention group become more engaged in their care, but they had improved clinical outcomes—including significantly reduced Hemoglobin A1c levels—while the control group did not change.¹

Patient-centered care has also been shown to reduce the chance of misdiagnosis due to poor communication.²

“At BCBSMA, our corporate promise is to put our member’s health first, so patient-centered care is fundamental,” says Safran.

“Therefore, we routinely include goals related to patient-centered care and the systems to support it in our provider incentive programs.”

To learn more about the IOM’s report, go to www.iom.edu.™

Medical Policy Update

Access the latest updates to medical policies and other documents via:

- [www.bluecrossma.com/provider>Medical Policies](http://www.bluecrossma.com/provider>Medical Policies)
- Fax-on-Demand at 1-888-633-7654

### Corneal Pachymetry, 391.
- Updated footnote 9 to note medically necessary ICD-9 CM diagnoses for all Plans, excluding Medicare Advantage members.
- After review of local Medicare coverage determination:
  - Clarified the fifth-digit ICD-9-CM medically necessary diagnoses under footnote 8,365.81-89
  - Added ICD-9-CM diagnosis 377.14 reporting glaucomatous atrophy of optic disc
  - Removed corneal pachymetry as a result of a complication of refractive surgery under utilization guidelines for Medicare Advantage members.

### Cytoreduction and Hyperthermic Intraperitoneal Chemotherapy for the Treatment of Peritoneal Carcinomatosis of Gastrointestinal Origin, 048.
- Added coverage for cytoreduction and hyperthermic intraperitoneal chemotherapy for the treatment of pseudomyxoma peritonei (PMP) confined to the abdomen. Effective 3/1/08.

### Implantable Devices for Hearing Loss, 087.
- Clarified the investigational use of Implantable Bone Conduction/ Bone Anchored Hearing Aids (BAHA) for indications other than covered uses. This includes use in patients with, but not limited to, bilateral sensorineural hearing loss.

### Incontinence Therapy, 072.
- Clarified coverage of sacral nerve stimulation for urinary incontinence in patients who have not responded to prior behavioral and pharmacologic interventions, when incontinence is not related to a neurologic condition.

### IVF, 086.
- Added coverage language pertaining to determination of eligibility for infertility services, including Assisted Reproductive Technologies (ART) for members who have not previously been defined as infertile and do not meet the definition of infertility as noted in Medical Policy 086. Effective 4/08.
- Required number of semen analyses increased to two for the diagnosis of male factor. Effective 4/08.

### Mammography Computer-Aided Detection, 125.
- BCBSMA has postponed the implementation of coverage exclusion of CPT code 77052 (announced in the August 2007 issue of Provider Focus) pending an evaluation of new evidence provided by local physician experts.

### Medical Technology Assessment Non-covered Services, 400.
- Added coverage for fibrin glue under CPT code 46706 for treatment of anal fistula only. Effective 3/1/08.
- Added to the non-covered list:

### Ultrasound, 007.
- Added the following clinical indications to the list of medically necessary indications for OB ultrasound. Effective 12/07.
  - Rh incompatibility (ICD-9-CM 656.13)
  - Hemolytic disease of fetus due to isoimmunization (ICD-9-CM 773.0-773.5).
**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. - 5:30 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. - 5:30 p.m.

- **Non-claims-related issues:**
  Provider Relations, all provider types: **1-800-316-BLUE (2583)**

- **Provider Enrollment and Credentialing**: **1-800-419-4419**
  For questions on the status of managed care or indemnity applications or recredentialing application packages.

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**Attention Behavioral Health Providers:**
Providerfocus now has a section just for you! See pages 4-6.

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**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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Provider Education and Communications
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Landmark Center, MS 01/08
401 Park Drive
Boston, MA  02215-3326

—or—
E-mail the editor at:
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