

# Special Edition Network News

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## Announcement

### 2009-2010 Influenza season reminders and guidelines

In anticipation of the 2009-2010 flu season, please make plans to immunize your patients against influenza. We also want to emphasize the importance of immunizing yourself and your staff. Not only will protecting your staff against the flu reduce absenteeism, but it will also minimize transmission of the flu between your staff, patients who come to your office for flu treatment and those who come in for routine medical care. Preventing the transmission of influenza will be very important. We hope you will take measures to immunize your staff and educate patients. The Centers for Disease Control and Prevention (CDC) website has many educational flyers and posters available for easy download in a variety of languages at <http://www.cdc.gov/flu/professionals/index.htm>.

## 2009 Recommendations for immunization practices

On July 24, 2009 the CDC released the 2009 Recommendations of the Advisory Committee on Immunization Practices (ACIP), for Prevention and

Control of seasonal flu with vaccines <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0724a1.htm>. Recent media coverage has highlighted H1N1, but we want to stress the importance of encouraging your patients to get an annual flu vaccine. For updated H1N1 information, please visit [www.flu.gov](http://www.flu.gov) frequently. California providers can also access [www.CalPanFlu.org](http://www.CalPanFlu.org) to order H1N1 vaccine and report usage.

## Resources for culturally appropriate communications

Additionally, please remember that culturally appropriate communications and sensitivity to gender are always important when discussing treatments and prevention measures with your patients. Cultural beliefs and values play an important role in getting people to be compliant. Industry Collaborative Effort (ICE) and a team of nationwide healthcare professionals developed culturally appropriate resources to address the service requirements and legal mandates challenging busy practices today. This link will direct you to the ICE Toolkit: [http://www.iceforhealth.org/library/documents/ICE\\_Booklet.pdf](http://www.iceforhealth.org/library/documents/ICE_Booklet.pdf)

1 Centers for Disease Control and Prevention, MMWR June 28, 2006. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr55e628a1.htm>

# Important Reminders

## Encourage a dialogue about colorectal cancer preventive testing

Your patients value your guidance about important health issues. That's why we encourage you to discuss colorectal cancer screening, and share with them that approximately one third of colorectal cancer (CRC) deaths could be avoided if people over 50-years-old were routinely screened with any of the recommended tests. Colorectal cancer, which affects both men and women, is second only to lung cancer as a cause of cancer-related death in the U.S. Over 90 percent of cases are diagnosed in those 50 or older, but screenings may be indicated earlier for people at increased risk. (*CDC Screening Guidelines*)

Surveys of members have identified that one barrier to screening is fear of the tests or the preparation for endoscopic exams. Your encouragement and deciding the right test for each individual will help patients choose to be tested and promote early detection. Providing educational materials or directing your patients to helpful resources can encourage screening acceptance.

## Sensitivity to gender and culturally appropriate communication help when discussing this sensitive subject

Culturally appropriate communications and sensitivity to gender go a long way when discussing colorectal cancer screening options with your patients. Cultural beliefs and values play an important role in getting people screened. Gender preferences may also play a role in achieving screening compliance. Industry Collaborative

Effort (ICE) and a team of nationwide healthcare professionals developed culturally appropriate resources to address the service requirements and legal mandates challenging busy practices today. This link will direct you to the ICE Toolkit: [http://www.iceforhealth.org/library/documents/ICE\\_Booklet.pdf](http://www.iceforhealth.org/library/documents/ICE_Booklet.pdf)

## Your recommendation could save a life. Reinforce to your patients:

- Not to avoid or delay getting screened – their lives may depend on it
- The testing options and preparations can be tailored to patient's needs and preferences
- Colorectal cancer often causes no symptoms until it has reached a relatively advanced stage
- Early detection greatly improves the chances of a cure

## We're reaching members about screening – by phone

In 2009, we identified members for whom we had no record of a current screening, based on guideline recommendations. Using Eliza Corporation's Interactive Voice Response (IVR), the targeted members received a message to discuss with their providers the best colorectal cancer screening option for them. Plans for 2010 include continuing the IVR telephonic messages to members.

For more information and resources, please visit [cdc.gov/cancer/colorectal/](http://cdc.gov/cancer/colorectal/).

## Case Management is available to serve you

Case Management is a program designed to assist members with complex care needs. Complex care needs might include complications from chronic conditions, acute illness or injury. Case managers may be able to help with navigating the health system, identifying and engaging community resources, benefit management or transitions to other levels of care. For more information about case management or to make a referral, call **888-613-1130**. For a Medicare Advantage member, call **866-797-9884**.

## Keeping your information current in our web-based provider directory

Anthem Blue Cross has a Web-based physician directory for easy reference by our members and your patients. It's important that your information be as current as possible to help members during their selection process. Please take a moment to check your information at [anthem.com/ca](http://anthem.com/ca)

The directories should include the following information: name, gender, specialty, hospital affiliations, medical group affiliations if applicable, board certification, acceptance of new patients, languages spoken by practitioner or clinical staff and office locations.

## Steps for checking your Web-based provider directory information

1. Log on to the Anthem Blue Cross website.
2. Select **Provider** then **Find a Provider**.
3. Choose **Blue Card** or **Local California Providers**.
4. Select **Visitor Search**.
5. Choose **plan type, plan** and **provider type** from the drop down menu and then select **Next**.
6. Select a combination of **City and State** or **Zip Code and State** or select the **County** and view results.
7. Select your name to review your information.

## What to do if your information needs to be updated

- HMO Provider: Please submit data changes to your medical group administration and they'll initiate the provider information update process.
- PPO Provider: Please submit data changes via written request on an official letterhead. The letter may be submitted by e-mail to the provider shared mailbox address: **Provider\_Database-Anthem-Wellpoint@wellpoint.com/** (Please note the underscore between Provider and Database.)
- Updated information can also be faxed to: **818-234-2836** and **818-234-2935**.

Members and prospective members may access the Web-based Provider and Hospital directories at [anthem.com/ca](http://anthem.com/ca).

Once on the site, members can click on "Find a Doctor" and search our Provider directory to find a doctor or a hospital in their area. Hard copies may be printed by using the "Self Print" option. The Web-based directories are available in English and Spanish.

Members who do not have Internet access should call the customer service telephone number listed on the member's ID card.

Thank you for keeping your information current.

# Guidelines

## 2009 Provider access standards

Anthem Blue Cross has established the following Commercial and Medicare Advantage access standards within our health care networks for preventive and routine primary care appointments, as well as urgent, emergency and after-hours care.

### Access standards for medical care

#### Commercial Access Standards

Type of Care	Standard
Regular and Routine Care Appointment	30 Calendar days: Members report that they “Usually” or “Always” get a routine care appointment at a doctors office or a clinic as soon as they think they need it
Urgent Care Appointments	24 Hours: Members report that they “Usually” or “Always” get an urgent care appointment as soon as they think they need it
Emergency Care Appointments*	Members have immediate access to emergency care
Consult/Specialty Referral	14 Calendar days: Members report that they “Usually” or “Always” can easily get a specialist appointment
Access to After-hours Care	Available 24 hours/day. Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent matters, a mechanism to reach a physician.
Office Appointment Wait Time	Usually members do not have to wait longer than 15 minutes to see a physician or his/her designee
Access to Telephone Service (obtain information about how to access clinical care and how to resolve problems)	Available 24 hours/day. Reach a live person within (45) seconds Abandonment rate of < or = 5 percent

#### Medicare Advantage Access Standards

Type of Care	Standard
Regular and Routine Care Appointment	14 Calendar days: Members report that they “Usually” or “Always” get a routine care appointment at a doctor’s office or a clinic as soon as they think they need it; 60 calendar days for preventive care treatment
Urgent Care Appointments	48 Hours: Members report that they “Usually” or “Always” get an urgent care appointment as soon as they think they need it
Emergency Care Appointments*	Members have immediate access to emergency care
Consult/Specialty Referral	14 Calendar days: Members report that they “Usually” or “Always” can easily get a specialist appointment
Access to After-hours Care	Available 24 hours/day. Member to reach a recorded message or a live voice response providing emergency care instructions and for non-emergent (urgent) matters, a mechanism to reach a physician or on-call designee outside of routine office hours
Office Appointment Wait Time	Usually members do not have to wait longer than 15 minutes to see a physician or his/her designee

### Access standards for behavioral health and EAP practitioners

Type of Care	Standard
Non-Life Threatening Emergency Care Within 6 hours	6 Hours
Urgent Needs Within 48 hours	48 Hours
Routine Office Visit 10 Working days	10 Business days(BH); 5 Business days (EAP)
Access to After-hours Care	Available 24 hours/ 7 days. Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent matters a mechanism to reach a Behavioral Health provider
Telephone Access to Screening and Triage	Callers reach a non-recorded voice within 30 seconds. Because BCC does not perform centralized referral and triage for BH and EAP services, this standard is not applicable
Abandonment Rates	Not to exceed 5 percent at any given time. Because Anthem Blue Cross does not perform centralized referral and triage for BH and EAP services, this standard is not applicable

\* California law requires health plans to follow the “prudent layperson” standard in providing directions for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any “prudent layperson” would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after hours answering service staff that callers who believe they are experiencing an emergency, should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct members to call 911 or go to the emergency room if they believe they’re experiencing an emergency.

## 2009 revised medical record review standards

Our Medical Record Review (MRR) standards have recently undergone several revisions. This will impact our network primary care providers (PCPs). The goal is to adopt one MRR process across our enterprise.

Our company has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. We perform medical record reviews to assess network PCPs' compliance with current medical record standards recognized by the National Committee for Quality Assurance (NCQA). All reviews are conducted by a nurse under the supervision of the local Medical Director.

These MRRs will be performed annually on a percentage of randomly chosen PCPs who are identified through claims and the HEDIS<sup>®</sup> process (Healthcare Effectiveness Data and Information Set) and who are contracted with our managed care products. These products include POS, HMO, PPO, State Sponsored Business and Medicare Advantage. Typically, the timeline for this process will be June through September annually. In order to pass the review, an office must score 80percent or greater. If a practitioner fails to meet the company's standard of 80percent, a re-review is conducted within six months.

MRRs are not required if the PCP's office has Electronic Medical Records (EMR) or the office has been recognized by the NCQA Physician Practice Connection Program.

There are two (2) sections on the audit tool: Office Specific Questions (written policies) and Chart Elements/Content and Clinical Documentation

(organization of medical records and preventive health service documentation).

To review these standards on our website, please visit [www.anthem.com/ca](http://www.anthem.com/ca) and select the "Health Information" tab, then select "Quality" from the drop-down menu and select the "Medical Record Standards" link. To obtain a printed copy of the medical record review guidelines, please call **877-273-4189**.

Thank you in advance for your assistance in this very important quality initiative.

## Advance directives reminder

Please remember to include documentation of an advance directive in a prominent part of a Medicare Advantage member's medical record, and include a copy of the directive in the medical record. This is a NCQA/CMS requirement. For more information on Anthem Blue Cross' Medical Record Standards, log into <http://provider2.anthem.com/wps/porta/ebpmybacc> and go to > Operations Manuals > Anthem Blue Cross PPO Operations Manual > Quality Improvement section > Medical Record Standards.

## Preventive health guidelines

Routine exams and screenings can catch possible health problems early — allowing patients to get treatment or make lifestyle changes before a condition becomes more serious. For a current and complete listing of recommended preventive care and immunization guidelines, visit our provider website at [anthem.com/ca](http://anthem.com/ca) and select the "Health Information" tab, then select "Practice Guidelines." You can also request a printed copy by calling **877-273-4189**.

These guidelines reflect recommendations for average risk individuals and are intended to help patients manage their health. These guidelines are not intended to replace their doctors' recommendations. We encourage members to talk to their doctors about other exams, screenings, and immunizations that are appropriate for them and their families. The guidelines are based on recommendations by independent national health care organizations, including the American Academy of Pediatrics, the American Academy of Family Physicians and the U.S. Preventive Services Task Force.

Each member's benefit plan may or may not cover all preventive services described on [anthem.com](http://anthem.com). For more complete information on their benefits coverage, please refer Anthem Blue Cross members to their certificate of coverage, where they'll find details about benefits, limitations and exclusions. Or they can call the customer service number listed on their ID card.

## Member rights and responsibilities statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefits plan. One of the first steps is for patients and providers to understand the rights and responsibilities of Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company members.

While the following information applies to members, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company has included it here for your reference and for adherence to treating members appropriately:

### Members/patients have the right to:

- Receive clear and accurate information about Anthem Blue Cross, their rights and responsibilities, their health plan benefits and services and how and when they can use them.
- Receive the names and contact information of participating physicians, hospitals, pharmacies and other health care providers available to them.
- Be treated with courtesy, respect and dignity.
- Protect their privacy and have their personal health information kept secure and confidential.
- Be involved with their doctors and other health care professionals in decision-making regarding their health care.
- Talk over their health care needs with the health care professionals caring for them, including having a clear and open discussion about appropriate or medically necessary care available for their condition, without concern for the cost or whether it's covered by their health plan benefits.
- Make a written or spoken complaint about the care or service they received from a participating health care professional or provider, or about the service they received from their health plan. Patients may appeal any decision made relating to them or their health plan benefits and/or health plan services. (They are asked to please refer to the complaints and grievance instructions on the Anthem Blue Cross website or in their Evidence of Coverage for how to proceed.).
- Write to Anthem Blue Cross with ideas or questions about this statement on member rights and responsibilities. Letters can be sent to:

Quality Improvement Department  
Attn: Rights and Responsibilities  
Mail Stop: AC 12G  
P.O. Box 70000  
Van Nuys, CA 91470-0001

### Member responsibilities

- To assist participating health care professionals and providers in meeting these responsibilities, it is the members' duty to:
  - Provide complete and accurate information (to the extent possible) about themselves, their health care status and history
- To the best of their ability, work with their doctor to be aware of and understand their health issues so that you can agree to treatment goals together
- Follow the prescribed medical treatment plan and health care instructions that the member has agreed upon with the doctor and let the doctor know if the member decides to take part in any Anthem Blue Cross-sponsored health activity or program
- Treat all health care professionals and staff with courtesy and respect
- Keep scheduled appointments with the doctor, and call the doctor's office if the member has a delay or cancellation
- Members should read and understand to the best of their ability all materials concerning their health benefits, or ask for help if they need it

### Appropriate 911/emergency care procedures

Emergency services are services provided in or out of the service area in connection with the initial treatment of a medical or psychiatric emergency and are available 24 hours a day and seven (7) days a week.

A member who considers a medical or psychiatric condition to be an emergency should be instructed to call 911 or go to the nearest hospital emergency room immediately. Anthem Blue Cross covers emergency services that are necessary to screen and stabilize a condition. No authorization or pre-certification is needed if the enrollee reasonably believes that an

emergency medical or psychiatric condition exists. Once the condition is stabilized, the member's physician should be contacted for authorization of any additional medical services. A member should be directed to call the telephone number on the back of the member's Anthem Blue Cross ID card with any questions.

**A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately. Examples of medical emergencies include:**

- Severe pain
- Chest pains
- Heavy bleeding
- Sudden weakness or numbness of the face, arm or leg on one side of the body
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Active labor
- Attempted suicide
- Suicidal/Homicidal Ideation
- Acute Psychosis
- Hazardous drug reactions/interactions

California law requires health plans to follow the "prudent layperson" standard in providing directions for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any "prudent layperson" would have considered the situation to be an emergency. A "prudent layperson" is a person who is without medical training and who draws on practical experience when making a decision regarding whether emergency medical treatment is necessary. Therefore, Anthem Blue Cross expects all HMO and PPO practitioners to instruct their after-hours answering service

staff that callers who believe they are experiencing an emergency should be instructed to dial 911 or go directly to the emergency room. If emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted at a later date. Answering machine instructions must also direct members to call 911 or go to the emergency room if they believe they are experiencing an emergency.

### Practice guidelines and medical policies available on the web

Anthem Blue Cross considers clinical practice guidelines to be an important part of our medical care delivery system and requires contracted providers and PMG/IPAs to adopt our practice guidelines. The most current Anthem Blue Cross adopted clinical practice and preventive health guidelines are available on the Anthem Blue Cross website including guidelines for Oncology, Heart Failure Condition Care, and Vascular at Risk programs. To access the clinical practice or preventive guidelines from our website, go to the "Provider" home page at [anthem.com/ca](http://anthem.com/ca). Under the "Health Information" tab, select "Practice Guidelines" from the drop-down menu. Upon request, we provide copies of the guidelines to Anthem Blue Cross contracted PMG/IPAs and providers. To obtain a hard copy, please call **877-273-4189**. Current medical policies adopted by Anthem Blue Cross are also available on the Anthem Blue Cross web site. The "Medical Policy and Clinical UM Guidelines" link can be found in the blue quick-links section located on the left-hand side of the Provider landing pages.

### 2009 HEDIS® season!

We would like to extend our thanks to those of you who participated in the Healthcare Effectiveness Data and Information Set (HEDIS®) project this year. The time frame for collecting HEDIS® information is very limited and we appreciate your cooperation and timeliness when submitting the requested medical record information and/or scheduling the on-site appointment with the copy service.

We continually strive to improve our HEDIS® rates and we cannot do it without our entire physician network. Many of the HEDIS® results are a reflection of the documentation of the care our members receive from their physicians.

Results of our 2009 HEDIS® review (measurement year 2008) have been submitted to the National Committee for Quality Assurance, where they will be compiled and compared to the rates of other health plans nationally, as well as regionally. While we had strong performances in Diabetes Care; Respiratory Conditions and Prevention Screenings (Immunizations; Breast and Colorectal Cancer), we do not want to be remiss and forgo opportunities for intervention strategies. Careful planning, implementation and evaluation are ahead for us all.

In an effort to prepare for the next time around, Anthem Blue Cross wanted you to be aware of the new measures that will be reported in 2010.

- *Adult (18-74 y/o) BMI Assessment* – Documentation in the medical record must indicate the date of the BMI and the BMI value.
- *Weight Assessment; Counseling for Nutrition and Physical Activity for Children/Adolescent (2-17 y/o)* who had evidence of "BMI percentile documentation", "Counseling for Nutrition" and "Counseling for Physical Activity" during 2008.

- *Childhood Immunization* – Two hepatitis A; Three rotavirus (Rota); and Two influenza (flu) vaccines (given before second birthday). Since the look back period for HEDIS reporting is on the prior year data, documentation will need to begin in 2009.
- *Adolescent Immunization* – Has returned -The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

Again, we thank you and your staff for demonstrating teamwork and partnership as we work together to improve the health of our members, your patients. For further information regarding our Quality Improvement program, please refer to the 'provider' section of our website at [www.anthem.com/ca](http://www.anthem.com/ca), enter, and click on 'Health Information', then 'Quality'.

Anthem Blue Cross  
PO Box 4330  
Woodland Hills CA 91365-4330  
Attn Anthem Blue Cross Communications  
[anthem.com/ca/home-providers.html](http://anthem.com/ca/home-providers.html)



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Anthem Blue Cross  
P.O. Box 4330  
Woodland Hills, CA 91365-4330  
Attn: Anthem Blue Cross Communications

Fax: 818-234-4386  
E-mail: [Prov.Communications@WellPoint.com](mailto:Prov.Communications@WellPoint.com)

Visit us on the Web at [anthem.com/ca/home-providers.html](http://anthem.com/ca/home-providers.html)