

Health care reform. What do you need to know?

What is Anthem Blue Cross' position on the new health care legislation?

Our priority remains in meeting the health care benefit needs of our members and ensuring they have access to affordable, high-quality care. Affordability is more important than ever before, and we remain concerned the bill signed into law by the President does not address long-term cost containment measures that will make the system sustainable.

Does the new law impact my participation with Anthem Blue Cross?

The health care reform legislation does not alter our current provider networks or your status as a participating practitioner with Anthem Blue Cross.

How will the new health care law change my day to day business with Anthem Blue Cross?

For the immediate future, your day to day business processes will not change. The implications of the new legislation will be phased in over a multi-year implementation period, beginning in the coming months. We will continue to communicate any impact these changes may have to current business processes as updates become available.

Will I see a change in patient policies or payment?

The new legislation will impact several elements of new and renewed policies beginning Sept. 23, 2010. Examples

include allowing members to add dependents up to age 26 (regardless of student status), eliminating lifetime limits on policies, and removing member cost sharing for preventive benefits (as defined by the legislation). As a proactive measure, beginning June 1, Anthem Blue Cross will automatically retain dependents up to age 26 on their parents' policies in both fully insured group and individual health plans. Self-insured policy members will have the option of not offering this extended coverage. Many of the more significant changes of the law are set to be effective beginning Jan. 1, 2014.

As a participating practitioner, what action do I need to take?

As previously mentioned, Anthem Blue Cross will continue to provide you with updates about our implementation of health care reform as our teams prepare for changes to member policies and/or business processes. You may want to contact your professional advisors to determine the impacts, if any, of health care reform to your business. We continue to be focused on providing excellent service to our provider communities.

What should I do when my patients have questions about health care reform? How can I help them?

We know that our members, customers, and providers will all be impacted by health care reform. To help answer questions around the new legislation,

we have launched a website dedicated to helping the public understand the many parts of health care reform. The site, www.healthychat.com, encourages open forum discussion and is designed to answer specific questions about all health care related topics. If you have questions about how health care reform will impact you or your patients, please visit www.healthychat.com to submit your questions. Additionally, if you have patients that have unanswered questions about health care reform, please encourage them to visit www.healthychat.com and join the discussion. Healthychat.com is monitored daily during business hours and responses to questions are posted within 24 hours.



Expedited Appeal process

Appeals related to urgent clinical issues, prospective or concurrent inpatient services are reviewed through the Expedited Appeal Process, resolved and the decision communicated in writing to the member/member's designee and the provider or facility rendering care within 72 hours of receipt of the appeal. Medical records should be sent to the *Grievance and Appeals* department upon discharge.

The intent of expediting an appeal is to assure that no harm comes to a member's health. If the appeal request does not meet the criteria for an expedited review, the member and provider are notified in writing within 72 hours of the request. The letter provides the reason for denial and explains the standard appeal process, including the 30 calendar day resolution timeframes. The medical record should be submitted for the appeal.

Upcoming Webinar - "How to Submit a Corrected Claim - The Right Way"

Save the date...December 15! Simply email the following information to network.education@wellpoint.com

- Your business email
- Your Name (first, last)
- Area code/phone number, ext.
- Your Provider name
- Your NPI and Tax ID
- Indicate webinar date

Got online registration? Access to e-courses, webinars and seminars ... new and improved!

Anthem Blue Cross Provider Network Education, has implemented a "new" electronic, online registration process for all of our provider learning opportunities. This includes our e-courses, webinars and seminars.

For those of you who have previously registered for our online e-courses, you will need to re-register.

Are you ready to get started?

- Paste wellpoint.intevista.com/Home.aspx into your Internet browser window. Save the website to your Internet browser favorites.
- Click on "Register" in the upper right of the screen and to be taken to the registration page. Once registered, you'll receive a confirmation e-mail.
- Log in with your username and password, take e-courses and RSVP for any upcoming webinar or seminar.

For questions, email us at network.education@wellpoint.com.

Effective April 1, 2010: Easier access to precertification/preauthorization information for out-of-area Blue members

We are pleased to announce enhancements to the BlueCard Eligibility®Line. These changes will improve your experience in verifying eligibility and obtaining precertification/preauthorization information for your out-of-area Blue members.

If calling 800-676-BLUE (2583) to obtain precertification/preauthorization only:

Effective April 1, 2010, when precertifications/preauthorizations are handled separately from eligibility verifications, calls will be routed directly to the area that handles precertifications/preauthorizations.

You will have four options to choose from:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment (DME)

Upon making your selection, you'll be transferred to the appropriate area to service your specific request.

If calling 800-676-BLUE (2583) to obtain eligibility only or if you need both eligibility and precertification/preauthorization:

Your call will be handled like it is today; select the option to obtain eligibility and precertification/preauthorization information. Your eligibility inquiry will be addressed, then you'll be transferred to the precertification/preauthorization area. If you have questions please call **800-677-6669**.

Mental Health Parity update – changes effective July 1!

To comply with regulations issued by the federal government on Feb. 2, 2010, some benefits in plans covered by the Mental Health Parity and Addition Equity Act (MHP) will change. Some of the benefit changes include applying no cost share or coinsurance to outpatient facility or professional mental health services, depending on the plan.

MHP is one of several federal health care reform laws that are creating a significant and immediate impact on employers. The new legislation prohibits group health plans that provide mental health and/or substance abuse disorder benefits from applying “financial requirements” or “treatment limits” that are more restrictive than the “predominant” financial requirement or treatment limit that applies to “substantially all” medical/surgical benefits. We are working to ensure the health plans we offer fully comply with the provisions contained in MHP.

MHP applies to all employer groups with more than 50 total employees. This includes all fully insured and self-funded employer plans, governmental plans, union plans and church plans, however, self-funded governmental plans may opt out. In California, some plans not covered by MHP may still be

covered by California Mental Health Parity legislation.

When do these MHP changes take effect?

The new regulations apply to group plan years beginning on or after July 1, 2010. This includes new groups and groups whose renewal dates are on or after July 1, 2010. Employers who renewed between November 2009 and June 2010 comply with the regulations based on the original interpretation of the law but may need to make additional changes at their next renewal.

Does a plan have to include coverage for mental health and substance abuse services?

No, the law does not require that a health plan cover any mental health or substance abuse conditions. Accordingly, a health plan could exclude coverage for all conditions or only exclude certain conditions, such as autism, smoking cessation, etc. However, if the plan is fully insured, state law may require coverage for mental health and substance abuse, in which case, a group could not elect to exclude coverage.

Also, if a plan covers a mental health or substance abuse condition, it must provide coverage for that condition in the inpatient (including emergency room) and outpatient settings and for prescription drugs.

As a Provider, what do these MHP changes mean to me?

Be sure to re-confirm the benefits for your Anthem Blue Cross patients, including but not limited to, copay, coinsurance, deductible and limitations, either on-line in ProviderAccess® or by calling the Customer Service number on the member’s identification card. Please note that MHP and California Mental Health Parity statutes do not remove or otherwise change utilization management procedures, so please be sure to confirm authorization requirements when confirming benefits and eligibility.

NEW FAX NUMBER

Effective immediately, fax your *Outpatient Treatment Report* (authorization requests) to 877-521-4787.

Notify us of changes within thirty (30) days

Use the *Practice Update Form* to change practice information*. The *Practice Update Form* is located on ProviderAccess® at **provider2.anthem.com/wps/portal/ebpmybcc** or in the *Exhibits* section of your provider manual.

*For tax identification number changes a Request for Tax Payer Identification Form (W-9) must also be included. Visit **www.irs.gov/pub/irs-pdf/fw9.pdf** to print a W-9 form.

Healthy Families is an Anthem Blue Cross product covered under your provider Agreement. Call 800-399-2421 for pre-authorization.

Network leasing

We have network leasing arrangements with a variety of organizations. We call them “Other Payors” and “Affiliates” and they use our network. Under the terms of your provider Agreement, members of those “Other Payors” and “Affiliates” are treated like Anthem Blue Cross members. As such, they are entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. The “Other Payors” and “Affiliates” list is available on ProviderAccess® at provider2.anthem.com/wps/portal/ebpmybcc.

Do you specialize in the treatment of Autism?

We keep this information on file to help refer members to you for these services. To ensure our database is current and up-to-date, **please fill out the enclosed insert and fax back to 858-278-7449.**

Do you know anyone who treats Autism? Please have them fax a request for network consideration, “Attention: Contracting Team” to 858-278-7449. The request should include a cover letter, resume, malpractice and state license.

Are you an EAP practitioner?

We need you! Please fax a current resume to 858-278-7449. Make sure to include your contact information, experience with alcohol and drug treatment and any other EAP experience.

Access to the Medical Director

Anthem Blue Cross Behavioral Health offers practitioners an opportunity for a peer-to-peer conversation about an adverse decision. If you’d like to discuss an adverse benefit determination, you may contact our Medical Director, Paul Keith, MD directly at 858-571-8129.

Customer Service IVR changes planned

To improve the customer experience and enhance self-service capabilities when utilizing the California Interactive Voice Response (IVR) system, we’ve implemented some changes. These enhancements will allow providers to quickly get needed information through standardized IVR navigation features and enhanced menu offerings. Changes were implemented through a two-step process. First changes released in July, followed by additional enhancements in August.

Changes from the July release included:

- Standardization of navigation features for the most used functions
- Clean up and standardization of verbiage such as “main menu” instead of “That’s all”
- Remove the requirement to enter the patient date of birth a second time when the caller selects “Benefits or Claims” and there are multiple dependents
- Change opt out function and allow providers to opt out from the end of Benefits and Claims details when the IVR cannot support the call
- An additional message at the end of the claims listing to: Inform user that any claim not on the list can be found with a specific date input and allow user to go back to the claims menu to enter the date

August enhanced menu offerings:

- Change Coverage menu and separate Benefits into new category
- Provide detailed benefits such as hospital, maternity, physician, etc. through self-service
- Provide message on processing lead-time and expected outcome i.e., how many business days to receive ID card, when the caller should expect to receive faxback, etc.

Get Connected! EDI Seminars available at no cost to you

We are pleased to announce an upcoming EDI (Electronic Data Interchange) seminar. The seminar provides a general overview of electronic claims submissions.

Register for one of the seminars on December 8, 2010 at www.anthem.com/edi>select **California**>**Communications**>**EDI Seminars**.

Parking is free and refreshments will be provided.

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

9 a.m. - 11 a.m. (Event #107)
2 p.m. - 4 p.m. (Event# 108)
Executive Board Room-Plaza Level

Coordination of care for behavioral health

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

It's important to keep in mind that PCPs prescribe approximately two-thirds of all psychotropic medications. In addition, patients who have complex conditions involving treatment by multiple providers often require care to be coordinated.

Coordination of care between behavioral health practitioners and PCPs is especially important for patients with high utilization of general medical services (such as those with severe chronic illnesses or medication seekers), patients suffering from chronic pain, eating disorders, autistic spectrum disorders and, patients referred to you by their PCP.

Anthem Blue Cross urges all of its providers to obtain the appropriate permission from these patients to coordinate care with their PCP at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the

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Anthem Blue Cross
Editor: Jeannieann Galambos
9655 Granite Ridge Drive, 6th Floor
San Diego, California 92123

3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
 - Diagnosis
 - Treatment plan
 - Referrals
 - Psychopharmacological medication (as applicable)

**Access to the form is available at anthem.com/ca>Providers>Provider Home>Answers@Anthem>Provider Forms*

Have you signed up for Rapid Updates yet?

Rapid Update is our web tool that allows us to share vital information* with you.

It's easy to register and it's free! Just go to anthem.com/ca>Providers>Provider Home>Network e-Mail Rapid Updates.

**Some updates may not apply to behavioral health practitioners.*

*Stay up-to-date! Join us for a free seminar coming to your area. For our 2010 fall schedule and registration details, just log in at anthem.com/ca>**Providers>Provider Home>Provider Network Education>Fall 2010.** We'll see you there!*

The Behavioral Health Network Update is also available online at anthem.com/ca

BEHAVIORAL HEALTH NETWORK UPDATE AUGUST 2010

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Enhancing provider data. We are improving behavioral health search options.

Anthem Blue Cross strives to improve our member experience on our provider directory web sites, compete in the national marketplace and promote timely access to behavioral health care. We are moving forward with an initiative to add new behavioral health provider data to our online provider directories.

In order to keep our online provider directories up to date and accurate, it is important for us to know your areas of expertise and other current practice information. This information helps our clinicians when directing referrals and members who access care directly.

It is important to notify us as soon as your practice status changes to help keep our provider systems current. The *Practice Profile* is a convenient option for updating your practice information. The *Practice Profile* is located on ProviderAccess® at provider2.anthem.com/wps/portal/ebpmybcc or in the *Exhibits* section of your *Anthem Blue Cross Behavioral Health Network/EAP Provider Operations Manual*.

Questions?

If you have any questions, you may contact Network Relations at 800-933-6633.

OPEN OR CLOSED PRACTICE STATUS

Is your practice currently accepting new patients?

_____ Yes _____ No

AREAS OF EXPERTISE*

Please check all that apply to your primary areas of practice focus and **fax back to 858-278-7449**.

_____ Behavioral Therapy for Autism Spectrum Disorder

_____ Transgender Issues

_____ Cognitive Behavioral Therapy (CBT)

**Note: This information is optional. If provided, it will be utilized in online provider directories available to our members.*

Fax the completed form to 858-278-7449.

Provider Signature: _____

Print Name: _____

Title: _____

Date: _____

Email: _____

NPI: _____



The results are in! 2010 spring Accessibility Survey

If you participated in the annual Anthem Blue Cross (Anthem) Accessibility Survey conducted in the fall of 2009, and did not meet one or both of the standards measured after hours, you received a call and/or correspondence from our Network Management team requesting corrective action. Those steps represent part of our efforts to improve the results and to help ensure practitioner accessibility for our members, your patients.

A follow-up survey that was conducted in May of the practitioners identified as non-compliant with one or more of the standards, showed both improved compliance with the standards, as well as the need for further improvement. Anthem would like to thank the practitioners who took action to ensure compliance with the Access Standards.

These telephone survey results are compiled and shared with you, our providers.

Standard	Compliance ≥ 85%		
	Psychiatrist	Psychologist, Clinician	EAP
Appropriate Emergency Instructions (callers who think they are experiencing an emergency should be referred to the nearest emergency room or to call 911)	81%	91%	95%
After-hours Care (provider can be reached after hours for urgent matters or can be left a message that will be returned within 4 hours (MD/DO) or within the next business day (psychologist, clinician). <i>Callers must be informed at the time of the call when the call will be returned.</i>)	38%	52%	51%

The most common reasons for non-compliant scores were related to key information missing on out-going messages on answering machines. With your help, we are hoping to see an improvement when this standard is measured again in the fall 2010 survey.

How you can make a difference

- Ensure your after-hours office staff, answering service and/or answering machine message specifically inform callers of when their urgent (non-emergent) calls will be returned (for example, within 4 hours, within the next business day).
- Ensure your out-going answering machine message properly informs callers to call 911 or go to the nearest emergency room in the case of an emergency

If you have any questions, refer to the *Quality Improvement* section of the January 2010 *Anthem Blue Cross Behavioral Health Network/EAP Provider Operations Manual* or contact Network Relations at 800-933-6633.