

Institutional Network News

In This Issue

	Page
Announcements	
• Medical referrals and preauthorization inquiry tool online	2
• Pharmacy benefit manager transition to Express Scripts, Inc.	2
Billing	
• 2010 FEP member benefit changes	3
• Walmart associates must have preauthorization for behavioral health services	4
• Attention electronic submitters: have you filed all your claims for 2009?	4
• Filing coordination of benefits claims electronically	5
• Important: change for present on admission reporting on 837 institutional claims	6
Network	
• Receive faxed information on FEP members	7
• Workers' Compensation medical provider network	8
• New toolkit: learn to communicate better with diverse patients	8
• Rapid Update: provider e-mail communication now available	9
• Network leasing	9
Program	
• The BlueCard® Program	9
• New wellness initiatives for federal employees	10
• Identifying and treating substance abuse in emergency rooms	11
• Promoting behavior change and compliance	11
• Helping the uninsured	12
• Giving the gift of life: organ donation	12
Guidelines	
• Understanding our medical policies	13
• Practice guidelines available on the web	13

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Announcements

Medical referrals and preauthorization inquiry tool online

ProviderAccess® has a new inquiry tool for viewing status of previously submitted medical authorization requests on:

- Inpatient admissions
- Outpatient services
- Office consultations

Except for HMO authorizations handled by the medical group, it is available to all provider types – ancillary, behavioral health, facility and professional – who submit referral or authorization requests to Anthem Blue Cross.

There are four options to search for a medical referral or authorization request:

- Certification number (also known as authorization number, case number or reference number)
- Member
- Date range
- Updated by health plan

These inquiry screens are printer friendly.

Accessing the online Medical Referrals and Preauthorization Inquiry is quick and easy. After logging in to ProviderAccess, click on the Referrals & Preauths tab. Then select one of the Medical Referral & Preauthorization Inquiry links.

Note: Your in house ProviderAccess administrator approves and grants rights for this inquiry function. Please direct questions about access to ProviderAccess tech support at **866-755-2680**.

Pharmacy benefit manager transitions to Express Scripts, Inc.

In April 2009 WellPoint, Inc. the parent company of Anthem Blue Cross, announced the acquisition of WellPoint NextRx, our affiliated pharmacy benefit manager by Express Scripts, Inc. Express Scripts is an industry-leading pharmacy benefit management company, and we are certain the transition will result in first-rate service for our members and providers. The transaction closed during the fourth quarter of 2009.

While ownership of our affiliated pharmacy benefit manager is changing, we anticipate few changes for our network health care providers. We will continue managing the drug list/formulary and will retain decision-making control of clinical pharmacy policies and programs upon close of the transaction. Additionally, the processes for submitting claims and completing prior authorization review will not change.

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We are working closely with Express Scripts to ensure a smooth transition of pharmacy benefits, and we are confident that members' medication therapy will not be disrupted.

We will keep you informed as the transition to Express Scripts continues. Thank you for your cooperation. If you have any questions, please contact your provider representative.

Billing

2010 FEP member benefit changes

Federal employees health benefits: 2010 Service Benefit plan members can be identified by the "R" prefix of the identification number.

Benefit	2010 Standard Option PPO	2010 Basic Option-Network Only
Referrals	Not Required	Not Required
Physician care Diagnostic and treatment services provided in the office	\$20 office visit copay \$30 specialist office visit copay 15% of our allowance	\$25 copay for primary care visits \$35 copay for specialist visits No copay for lab and X-rays
Preventive care Adult routine physicals and preventive screenings Well-child care (up to 22): routine physical exams, routine hearing tests, labs, immunizations and related office visits	New for 2010: copay credit for annual physical \$20 copay for primary care visits No out-of-pocket expenses for covered preventive screenings \$30 copay for specialist visits No out-of-pocket expenses for covered services	New for 2010: Copay credit for annual physical \$25 copay for primary care visits No out-of-pocket expenses for covered preventive Screenings \$35 copay for specialist visits No out-of-pocket expenses for covered services
Hospital care Inpatient Outpatient	\$200 per admission 15%* of our allowance (no deductible for surgery)	\$150 per day up to \$750 per admission \$75 per day per facility (waived for covered diagnostic tests)
Surgery Inpatient/outpatient physician care	15%* of our allowance	\$100 copay per performing surgeon
Maternity care Inpatient hospital care (precertification not required for normal delivery) Physician care including delivery and pre-and post-natal care	No out-of-pocket expenses for covered services No out-of-pocket expenses for covered services	\$150 copay per admission No out-of-pocket expenses for covered services

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Emergency care Accidental injury Medical emergency	Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Regular benefits for physician and hospital care*	\$75 copay for emergency room care \$30 copay for urgent care Same as for accidental injury
Prescriptions	Prescription drugs covered up to 90-day supply At the pharmacy 30% coinsurance for brands 20% coinsurance for generics Mail service No copay for generics (first 4 fills) \$10 copay for generics (additional fills) \$65 copay for brands (first 30 fills) \$50 copay for brands (additional fills)	Prescription drugs covered up to 34-day supply Retail pharmacy only No mail service \$10 copay for generics \$35 copay for formulary brands 50% coinsurance non-formulary brands (\$45 minimum)
Chiropractic care	\$20 copay per office visit; up to 12 spinal manipulations per calendar year	\$25 copay per office visit; up to 20 spinal manipulations per calendar year
Mental health and substance abuse	\$20 copay per office visit; \$200 per admission (prior approval required) \$30 copay per office visit for specialists	\$25 copay per office visit \$150 per day up to \$750 per admission (prior approval required)
Protection against catastrophic costs (out-of-pocket maximum)	\$5,000 member out-of-pocket maximum (PPO) or \$7,000 (combined PPO/non-PPO) per contract year	\$5,000 member out-of-pocket maximum per contract year.

* is subject to the calendar year deductible: \$300 per person or \$600 per family for 2010 Standard Option; No deductible for 2010 Basic Option. If you use a Non-PPO physician or other health care professional under Standard Option, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown in the table above. Basic Option does not provide benefits when you use Non-PPO providers. Do not rely on this chart alone. This is a summary of the features of the Anthem Blue Cross Service Benefit Plan. Before making a final decision, please read the plan's federal brochure (RI 71-005). All benefits are subject to the definitions, limitations and exclusions set forth in the federal brochure. For a contractual and complete description of the benefits available under the Service Benefit Plan, please refer to the 2010 Anthem Blue Cross Service Benefit Plan brochure.

Walmart associates must have preauthorization for behavioral health services

Walmart chose New Directions as their behavioral health vendor, effective January 1, 2010. New Directions is owned by Blue Cross and Blue Shield of Kansas City.

Walmart associates are required to get preauthorization for behavioral health services rendered in facilities, for both ambulatory and inpatient services. Additionally, behavioral health office visits will need preauthorization on the 9th visit per benefit year.

Visit ndhb.com for more information about New Directions.

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Attention electronic submitters: have you filed all claims for 2009?

As the year draws to a close, we encourage you to file all of your claims electronically, including outstanding A/R claims and claims with other coverage information. By filing electronic claims now, you can greet the New Year with a good start.

Filing claims electronically can help you save time, improving operating efficiency and cash flow for your practice or facility. Additionally, electronic claims filing helps decrease paperwork and reduce administrative expenses. You can also reduce the number of re-filed claims, errors and rejected claims by filing electronically. In addition, the electronic process provides easy-to-interpret reports and an audit trail to track claim submissions. If you have questions about the electronic filing process, call our EDI Solutions specialists Monday-Friday from 8 a.m.– 4:30 p.m. Pacific time at **800-227-3983**.

Filing coordination of benefits claims electronically

What, when, where, why and how

What?

Anthem Blue Cross secondary/tertiary claims can be filed electronically.

When?

Start today! Before you begin submitting secondary/tertiary claims electronically verify with your software vendor or clearinghouse that you have the ability to submit secondary/tertiary claims electronically.

Where?

File your secondary/tertiary claims electronically to Anthem Blue Cross.

Why?

What does this mean for you? Submitting secondary /tertiary claims electronically:

- Improves operating efficiencies
- Lowers administrative costs – postage, paper claim forms
- Provides a one-submission process
- Eliminates the need to submit paper Explanation of Benefits (EOBs)
- Provides an audit trail
- Less manual intervention
- Faster turn-around time
- Reduces processing delays

How?

EDI vendors have developed or enhanced their software to support sending COB claims electronically. Your software must contain the fields required to input data from the primary payer's explanation of benefits. For the COB filing requirements for Anthem Blue Cross go to [anthem.com/edi>California>Documents>HIPAA Companion Guide>Requirements for Filing Coordination of Benefits \(COB\) Electronically](http://anthem.com/edi>California>Documents>HIPAA Companion Guide>Requirements for Filing Coordination of Benefits (COB) Electronically).

These are just a few of the reasons why electronic claims submission should be your method of choice. We're sure you'll agree that when every dollar counts, it's

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good to know that Anthem Blue Cross secondary claims can be filed electronically. Electronic claims submission – the smart choice!

Please contact our EDI Solutions Helpdesk if you have questions about filing COB claims at **800-227-3983**.

Important: change for present on admission reporting on 837 institutional claims

Effective June 27, 2009, in compliance with ASC X12 HIR (HIPAA Implementation Guide Interpretation Requests) #511 Present on Admission Indicator, Anthem Blue Cross will require the following changes for POA submissions:

Note: Since original HIR did not accommodate a location for the reporting of the POA indicator for the submitted e-code, it was suggested to populate e-code POA information in the first byte following the “Z” or “X” value.

POA Reporting Structure:

POA values will be reported in Loop 2300 K301 as follows:

Location	File Value
Positions 1-3	POA
Position 4	Represents the POA indicator for the principal diagnosis code (HI01 with BK qualifier)
Position 5	Begins the reporting of POA indicators for all “other” diagnosis codes, if applicable (HI with BF qualifier)

- A “Z” or an “X” must be reported to indicate the end of reporting of the POA indicators for the “other” diagnosis codes
- The byte following the “Z” or “X” value represents the POA indicator for a submitted e-code (HI03 with BN Qualifier).
- If the segment ends in a “Z” or an “X” value, then the e-code was not submitted.

Examples showing reporting structure

- K3*POAYNU1Z1~ No exception handling, e-code submitted.
- K3*POAYNU1Z~ No exception handling, no e-code submitted.
- K3*POAYNU1XY~ Exception handling, e-code submitted.
- K3*POAYNU1X~ Exception handling, no e-code submitted.

POA examples

- *No e-code submitted* in HI03-external cause of injury with BN qualifier:
 - HI*BK:41091*BJ:486~ (Principle, and Admitting)
 - HI*BF:4019*BF:2859*BF:72887*BF:7295~ (four other diagnosis codes)
 - K3*POA1YNU1X~ Exception handling
 - K3*POA1YNU1Z~ No exception handling
- *A single e-code submitted* in HI03-external cause of injury with BN qualifier:
 - HI*BK:41091*BJ:486*BN:E8120~ (Principle, Admitting and External cause of injury)
 - HI*BF:4019*BF:2859*BF:72887*BF:7295~ (four other diagnosis codes)
 - K3*POAYNUYZY~ No exception handling
 - K3*POAYNU1XY~ Exception handling

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- An e-code submitted in the external cause of injury element HI03 with BN qualifier and additional e-codes submitted as other diagnoses in the HI segment with BF qualifier:
 - HI*BK:41091*BJ:486*BN:E8120~ (Principle, Admitting and External cause of injury)
 - HI*BF:4019*BF:2859*BF:E9470*BF:E9270~ (4 other diagnosis codes; 2 are e-codes)
 - K3*POAYYNNX~ Exception handling
 - K3*POAYYNNZY~ No exception handling

If you have any questions about POA reporting, please call the EDI Solutions Helpdesk at **800-227-3983**, e-mail edi.operations@wellpoint.com or use LiveChat at anthem.com/edi Monday through Friday, 8:00 a.m. - 4:30 p.m. Pacific time.

Network

Receive faxed information on FEP members

Beginning October 10, 2009, the following information can be obtained by fax:

- Member eligibility information
 - Policy effective/termination dates
 - Type of member enrollment
 - Medicare effective dates
 - Calendar year deductible accumulations
 - Catastrophic year-to-date accumulations
- Benefits information
 - Physician services
 - Hospital services
 - Dental
 - Pharmacy
 - Mental health
 - Rehabilitation
- Claims status
 - Date paid
 - Direction of payment
 - Amount of payment
 - Remittance date
 - Check information
 - Date of denial
 - Description of denial reason
- Claims mailing address
- Pre-certification

These are just a few of the reasons why electronic claims submission should be your method of choice. We're sure you'll agree that when every dollar counts, it's good to know that Anthem Blue Cross secondary claims can be filed electronically. Electronic claims submission – the smart choice!

Please contact our EDI Solutions Helpdesk if you have questions about filing COB claims at **800-227-3983**.

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Workers' compensation medical provider network

The Workers' Compensation Reform Legislation was conceived to tackle many of the primary cost drivers and related issues regarding the state Workers' Compensation system. The bill allows self-insured employers, third party administrators (TPA) and insurance carriers to form medical provider networks (MPNs).

An MPN is a group of health care providers selected by the insurance carrier, self-insured employer or TPA to provide medical care to injured workers. **The health care professionals must provide medical services to all injured workers including existing and new work related injuries.** By establishing an MPN, employers will be able to control the medical care of an injured worker's claim for most injuries.

We are providing access to our Prudent Buyer network and Occupational Medicine Network to use as a state-certified MPN for treating eligible injured workers. Our MPN currently provides network access, bill review, case management and utilization review services to insurance companies, TPAs and self-insured employers in California.

Please note that if you choose to terminate your participation in the workers' compensation network by terminating your contract, opting out, or if your demographic information is not current, you will not appear in our online directory thus causing you to be terminated from our client's MPN.

If you renew your contract, opt back in or update your demographic information, this will reinstate you into the Anthem Blue Cross workers' compensation network. However, this does not automatically reinstate you into the insurer or employer's MPN. To confirm your MPN status after one of the above occurs, please contact the insurer or employer directly.

For additional information about the obligations of the treating physician within the MPN other MPN issues, or if you do not treat Workers' Compensation patients, visit the Blue Cross' Workers' Compensation Services website at wcs.anthem.com/WCMCSHomePage.htm or call us at **866-700-2168**.

New toolkit: learn to communicate better with diverse patients

We invite you to check out **Caring for Diverse Populations: Better Communication, Better Care**, a new cultural competency resource for doctors and health care professionals. This valuable toolkit can help reach national goals for reducing health disparities caused by lack of culturally or linguistically appropriate care.

What is in the new toolkit?

The toolkit includes a compilation of the best resources available for improving cultural and linguistic competency, such as:

- Communication tools and tips for more successful patient encounters
- Commonly used signs and sentences in several non-English languages
- Guides for finding and working with interpreters and culturally competent office staff

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- Resource web links to low literacy and non-English language patient education materials
- Regulations and standards for culturally and linguistically appropriate services (CLAS)

The toolkit is based on work by the Industry Collaborative Effort (ICE) Cultural and Linguistic Workgroup, a volunteer group of providers, health plans, associations, state and federal agencies, accrediting bodies and other resources from public health entities.

How to get your free toolkit?

The new toolkit will be available in early 2010 on a new website dedicated to cultural and linguistic competency: FairHealthTogether.com or on CD. Contact your provider representative for more information about our cultural and linguistic resources. We're here to help.

Rapid Update: provider e-mail communication is now available

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient. Important need-to-know provider updates are a click away.

Rapid Update is our latest web tool for sharing vital information. It features short topic summaries and links that let you dig deeper into timely critical business information, but only when necessary:

- Important website updates
- System changes
- Fee schedules
- Medical Policy updates
- Mailed communication and more

It's easy to register. Just [click here](#), then start watching your e-mail.

Network leasing

We have network leasing arrangements with a variety of organizations, which we call "other payors." Other payors and affiliates 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. You can get the other payors list on the ProviderAccess section of our website at anthem.com/ca. If you do not have Internet access, please call **800-933-6633** for assistance.

Program

The BlueCard® program

BlueCard is a national program that lets Blue Plan members to get health care services while traveling or living in another Blue Plan's service area. The program

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links participating providers with all the Blue Plans across the nation through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide. The program allows providers to conveniently submit claims for patients from other Blue Plans, either domestic or international, to their local Blue Plan. For providers' convenience, the local Blue Plan is the single contact for all claims payments, customer service issues and adjustments for BlueCard and out-of-area claims.

For contracted providers, the BlueCard program offers a focal point for claims submission, payment and service for all BlueCard claims. The BlueCard program supports initiatives that help plans better work together to provide seamless service to providers.

The BlueCard program supports the plan-provider relationship in several ways:

- Providers can call **BlueCard Eligibility®** at **800-676-BLUE (2583)** or submit a HIPAA-compliant electronic eligibility inquiry (transaction 270) to their local host plan to obtain membership and coverage information for out-of-area members.
- The BlueCard host plan collects out-of-area claims and pays providers.
- The local host license is the single contact for the claims payments, customer service issues, provider education, and adjustments for BlueCard and other out-of-area claims.

New wellness initiatives for federal employees

Beginning January 1, 2010, the Federal Employee Program (FEP) will reward members when they complete either the adult **Blue Health Assessment** or a child's **BMI Assessment**.

About the programs

Blue Health Assessment: If an adult member completes the Blue Health Assessment, our health risk assessment, the copay for his or her subsequent annual physical examination or an individual preventive counseling visit will be waived. The member will receive a certificate for a preventive visit at no charge, with instructions to present the certificate to the doctor at the time of care.

BMI Assessment: Children ages five through 17 who complete a BMI assessment, and whose BMI is at or higher than the Center for Disease Control (CDC) threshold for overweight (85th percentile or higher), will receive a certificate to present at the time of care. The copays for up to four nutritional counseling visits will be waived. The member must complete the child BMI Assessment and will be directed to present the certificate to the physician at the time of care.

Steps for the provider

- Copays are not collected when certificate is presented. Reimbursement will be included when claim is filed to the local plan. Copays collected in error will require a refund.
- To ensure correct reimbursement, the claim must be filed with the appropriate evaluation/management procedure code and diagnosis for adults or the appropriate nutritional counseling codes and diagnosis for children.
- Certificate may be retained for records and is not required in submission of claim.

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- Child's certificate encompasses four visits. Sign and date each visit on the certificate.

Please call your local plan FEP customer service if you have questions.

Identifying and treating substance abuse in emergency rooms

Did you know even a brief intervention by a doctor has been shown to be helpful in encouraging patients to examine and decrease their substance abuse?

We think ER departments are critical to screening and diagnosing substance use disorders since many conditions that present in your setting may be due to underlying alcohol and drug use. That's why we're asking you to help identify and treat members at risk for alcohol and/or drug use and dependence. You can help ensure members receive appropriate interventions and are linked to treatment resources when needed. A 15- to 30-minute screening and a brief intervention, when needed, may help. This approach may result in more than 15% of the population of patients with substance abuse problems making healthier choices for a sustained period of time.

ERs will be reimbursed for structured screenings of Anthem Blue Cross members using the two CPT codes (99408 and 99409) that became available January 1, 2008. We also have a Physician Toolkit, available to you at no charge, includes a booklet with provider guidelines, a wall poster for exam rooms, screening tools and brochures you can distribute to your patients on opiates and alcohol. These materials can be downloaded from anthem.com/ca under provider information. If you would like a packet mailed to you, please contact Michael Command at Michael.Command@anthem.com or call 858-571-8352.

If a patient needs further evaluation and treatment for behavioral health services, please call the number on the back of their member ID card for more information about authorization requirements and benefits.

Promoting behavior change and compliance

In the hectic day-to-day office environment, it's often hard to find the time to motivate patients towards change and compliance. Trying to get patients to take their medications, eat healthier and get more exercise can be challenging and frustrating for doctors.

Stephen Rollnick and William R. Miller, authors of *"Motivational Interviewing (MI): Preparing People to Change,"* have identified a communication style that can save time and frustration when you're trying to motivate patients to change. It's designed to resolve ambivalence and build motivation for behavior change. The word "interviewing" is used because it involves careful listening and strategic questioning, rather than teaching, in order to help patients resolve their ambivalence about change. It's like a news reporter gathering facts for a story.

MI's therapeutic technique is designed to help people make meaningful personal changes in their lives. Whether you're trying to get them to quit smoking, take their cardiac medications, keep their cholesterol in check, or help them lose weight, MI techniques can assist with it all.

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The basic approach for Motivational Interviewing is OARS:

- O: Ask open-ended questions. “What brings you here today?” or “Tell me about what’s been happening since we last spoke?” Open-ended questions create a momentum to explore change.
- A: Affirm perceptions and strengths. Statements about how they accomplished something in the past will help them realize that they can make change. Affirmations can be wonderful rapport builders.
- R: Reflective listening. It’s key to this work. The best motivation you can give to your patients is to listen carefully.
- S: Summarize the conversation. Reflect back to the client what he or she has been telling you. This is an effective way to communicate your interest in a client, build rapport, and call attention to elements of the discussion to shift direction.

Want to learn more? Go to motivationalinterview.org or stay tuned for future provider bulletins for more information about motivational interviewing as a way to elicit positive behavior change in your patients.

*adapted from Miller, W.R. and Rollnick, S. “Motivational Interviewing: Preparing People to Change”, NY: Guilford Press, 2002

Helping the uninsured

Many uninsured people in our communities may be qualified to receive assistance. Anthem Blue Cross’ parent company, WellPoint, has a foundation that helps fund the Foundation for Health Care Coverage Education (FHCE), a national nonprofit organization committed to assisting uninsured individuals who are eligible to obtain health care coverage through federal and state programs.

The FHCE has announced it will help uninsured consumers identify and apply for health care coverage as part of its mission to improve the overall health of Americans throughout the United States.

We invite you to refer uninsured patients, or those who have uninsured family members, to FHCE for help getting health care coverage. Just call the Uninsured Hotline toll-free number at 800-234-1317. You can e-mail questions to fhceinfo@coverageforall.org or visit their website at coverageforall.org.

An estimated one-third of patients without insurance are eligible for some type of assistance. Those who are pregnant, or live in a household with children under age 19, are even more likely to qualify. Specific government programs have developed to assist working families.

Referred patients will receive caring and sensitive assistance from professionals in eligibility enrollment. This information will only be used to screen the individual for available assistance through government programs.

Giving the gift of life: organ donation

Each year, organ transplants save thousands of lives, and its success rate continues to rise. But there are far more potential recipients than donors, so more donations are urgently needed. Today, it’s possible to transplant more than 25 different organs and tissues. We encourage members to let you know about any

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plans they may have for organ donation. It's a unique opportunity to give the gift of life, and we encourage you to discuss it with your qualifying patients, including adults aged 18 and older and minors who have parental or guardian consent. More information about organ donation is available online at organdonor.gov/donor/index.htm.

Guidelines

Understanding our medical policies

Medical policies are created through the Office of Medical Policy and Technology Assessment and approved through the Medical Policy and Technology Assessment Committee (MPTAC). The MPTAC consists of external, practicing doctors, as well as doctors who are medical directors in our company. Anthem Blue Cross medical policy is based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners in relevant clinical areas, and any other relevant factors. The literature is reviewed regularly and monitored for new studies and evidence. For additional information please reference our medical policy ADMIN.00001 Medical Policy Formation, available on our website below.

Finding medical policies and utilization management guidelines is easier than ever thanks to a recent website upgrade. Simply go to bluecrossca.com/home-providers.html, then select **Providers>Learn More>Medical Policies and Clinical UM Guidelines**. Policies and guidelines are listed alphabetically by category or can be found using the search engine.

If you don't have Internet access, you can request a hard copy of specific medical policies or clinical UM guidelines by calling Provider Inquiry at **800-794-0838**.

Practice guidelines available online

Clinical practice guidelines are an important part of our medical care delivery system, so it's required that contracted providers and PMG/IPAs adopt them. Our most current clinical practice and preventive health guidelines are available on our website, including guidelines for musculoskeletal and low back pain. To access them online, go to the Provider home page at anthem.com/ca. Under the Health Information tab, select Practice Guidelines from the drop-down menu. We provide copies of the guidelines to contracted PMG/IPAs and providers upon request. Please call **877-273-4189** if you'd like a hard copy.

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