Stay up-to-date! Join us for a free seminar coming to your area. For our 2011 spring schedule and registration details, just log in at anthem.com/ca >Providers>Provider Home>Provider Network Education. We’ll see you there!

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

Come see what’s inside

- Behavioral Health Outpatient Authorization program
- Have you signed up for Rapid Updates?
- Timely Access Regulations
- Member rights and responsibilities
- Clinical practice and preventative guidelines
- Electronic Submitters
- Areas of Expertise available for BlueCard members
**Behavioral Health Outpatient Authorization Program**

Anthem Blue Cross implemented a behavioral health professional outpatient review program for its California membership in January of 2010. The review program allows us to monitor provider practice patterns which enforces our commitment to quality and cost-effective services for our members. Through claims analysis we have determined that the majority of our California members complete professional outpatient services within 8-10 visits. Based on this analysis, we decided to allow claims for up to 12 visits a year without prior authorization. If a member needs to be seen for more than 12 visits, an Outpatient Treatment Report (authorization request) must be submitted to our Behavioral Health Outpatient Team. The completed form can be faxed to our Utilization Management team for review, toll free, at 877-521-4787. This program applies to all fully insured PPO, HMO, EPO, or POS benefit plans. Please note that self-funded plans may have different requirements for prior authorization of behavioral health services. Always verify benefits, eligibility, and pre-authorization requirements with Customer Service or online through Provider Access prior to rendering service.

The Outpatient Treatment Report form is available in your Provider Manual or online at anthem.com/ca. For any questions, call the customer service number on the back of the member’s identification card.

**Notify us of changes within 30 days**

Use the Practice Update Form to report changes to your 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.

**Have you signed up for Rapid Updates?**

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.

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**Healthy Families Reminder**

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

**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.

**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.
Timely Access Regulations took effect on January 17, 2011

As you are aware from our previous communications, the Department of Managed Health Care (DMHC) has adopted new Timely Access to Non-Emergency Health Care Services Regulations (Timely Access Regulations) that went into effect on **January 17, 2011**. All health care service plans, including mental health, dental, vision, chiropractic, and acupuncture plans are required to implement policies, procedures, and systems necessary to ensure compliance with the Timely Access Regulations, including access to non-emergency health care services within prescribed timeframes (also referred to as the “time elapsed standards” or “appointment wait times”).

Anthem Blue Cross (Anthem) is committed to keeping you, our network partners, updated on our activities as we develop these policies and procedures to support compliance with the new regulations, including but not limited to, the time elapsed standards. We also expect that pursuant to the contract change notices previously sent, our providers will comply accordingly.

Based on recent questions and concerns posed by providers, we have realized that there may be some confusion that exists regarding how a provider office can comply with the time-elapsed standards. With that said, we appreciate that in certain circumstances the time-elapsed requirements may not be met. The Timely Access Regulations have provided a few exceptions to the time-elapsed standards to address these situations.

1. The waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant member record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

2. The member may “prefer” an appointment at a later date from a specific contracted provider. This situation should also be documented in the member’s record.

We hope this clarifies Anthem’s expectations and your obligations regarding the Timely Access Regulations. Our goal is to partner with our providers to successfully implement the new requirements with the least amount of difficulty and member abrasion. See below for additional information regarding our implementation of the Timely Access Regulations.

**Health Plan Compliance Activity to Date**

Our actions to date include but are not limited to:

- Expansion of a 24/7 Nursing Line which is now available to all of our members whereby they can reach a qualified professional who will provide triage and screening services
- Development of a compliance plan and filing of this plan with the DMHC
- Provider notices of contract and/or operations manual changes sent October 2010
- Provider Network Updates published November 2010, December 2010 (revision) and January 2011
- Internal training and communications for Anthem Blue Cross staff
- External communications with our physician and consumer committees

**Activity in Process**

Our teams are working diligently to implement procedures and systems to support compliance. The following examples include some of our current activities:

- Development of Appointment Availability Survey (through work with the Industry Collaborative Effort) which will be conducted between February and August of this year with our HMO provider groups only.
- Development of a compliance annual reporting work plan to ensure all required reporting is produced in accordance with DMHC required timelines.
Providers will be required to comply with the following Anthem Blue Cross’ Access Standards:

**Access Standards for Medical Professionals**

<table>
<thead>
<tr>
<th>ACCESS TO</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent appointments for Primary Care (PCP)</td>
<td>Must offer the appointment within 10 business days of the request.</td>
</tr>
<tr>
<td>Urgent Care appointments not requiring prior authorization</td>
<td>Must offer the appointment within 48 hours of request.</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist Physicians (SCP)</td>
<td>Must offer the appointment within 15 business days of the request.</td>
</tr>
<tr>
<td>Urgent Care appointments that require prior authorization</td>
<td>Must offer the appointment within 96 hours of the request.</td>
</tr>
<tr>
<td>Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)</td>
<td>Must offer the appointment within 15 business days of the request.</td>
</tr>
<tr>
<td>In-office waiting room time (this is an existing Anthem Blue Cross requirement and is not part of the new Timely Access regulation)</td>
<td>Usually members do not wait longer than 15 minutes to see a physician or his/her designee.</td>
</tr>
<tr>
<td>After Hours Care</td>
<td>Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back.</td>
</tr>
<tr>
<td>Emergency Care (California law requires health plans to follow the “prudent layperson” standard in providing direction 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 if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller believes they are experiencing an emergency.</td>
<td>Immediate Access to Emergency Care</td>
</tr>
<tr>
<td>Member Services by Telephone. Access to Member Service to obtain information about how to access clinical care and how to resolve problems (this is a plan responsibility and not a physician responsibility; also applies to our Behavioral Health members).</td>
<td>Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate &lt; 5%)</td>
</tr>
<tr>
<td></td>
<td>Member Nurse line available 24/7</td>
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</table>

Anthem Blue Cross - March 2011
### Access Standards for Behavioral Health and EAP Professionals

<table>
<thead>
<tr>
<th>ACCESS TO</th>
<th>STANDARD</th>
</tr>
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<tbody>
<tr>
<td>Emergency Care <em>(California law requires health plans to follow the “prudent layperson” standard in providing direction 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 if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller believes they are experiencing an emergency.)</em></td>
<td>Members are directed to 911 or the nearest emergency room</td>
</tr>
<tr>
<td>Non-Life Threatening Emergency Care</td>
<td>6 hours</td>
</tr>
<tr>
<td>Urgent Care (that does not require authorization)</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Care (that requires prior authorization)</td>
<td>96 hours</td>
</tr>
</tbody>
</table>
| Routine Office Visit/Non-urgent Appointment | 15 Business days (Psychiatrists)  
10 Business days (Non-Physician Mental Health Care Providers)  
5 Business days (EAP) |
| After Hours Care | Available 24 hours/7 days. Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Behavioral Health/EAP provider, and be informed when the call will be returned. |
| In office waiting room time *(this is an existing Anthem Blue Cross requirement and is not part of the new Timely Access regulation).* | Usually members do not have to wait longer than 15 minutes after their scheduled appointment to see a Behavioral Health/EAP provider. |

For additional information about the regulations, please visit the Department of Managed Health Care’s website at: [www.healthhelp.ca.gov/library/reports/news/fstimelyaccess.pdf](http://www.healthhelp.ca.gov/library/reports/news/fstimelyaccess.pdf). In addition, the final regulations are available at: [wpso.dmhc.ca.gov/regulations/docs/regs/20/1257296076228.pdf](http://wpso.dmhc.ca.gov/regulations/docs/regs/20/1257296076228.pdf). If you have further questions, please contact CA Contracting Support at 855-826-0711.
Clinical practice and preventive health guidelines

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually and updated as needed. The current guidelines are available on our website. Go to the “Provider” home page at anthem.com/ca > Providers > Health and Wellness > Practice Guidelines.

Behavioral Health Areas of Expertise available to BlueCard members

Every year over 98 million Blue members nationwide visit the Blue National Doctor & Hospital Finder at provider.bcbs.com/ and the Federal Employee Program (FEP) Online Provider Finder at fepblue.org/ seeking information about healthcare providers, including behavioral health practitioners. Members in California use anthem.com/ca.