Network Update
BEHAVIORAL HEALTH

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Behavioral Health Network Update, is published four times for our contracted providers.

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Editor: Jeannieann Galambos
Email: prov.communications@anthem.com
Health Care Reform Updates (including Health Insurance Exchange)

Important information available online

We invite you to visit our website and learn about the many ways health care reform and health insurance exchange may impact you. Information is added regularly. View the latest articles and all archived articles too. Go to our website, anthem.com/ca > Providers > Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Information.

Announcements and General Updates

From our Medical Director
Robert Friedman, MD

What about Ketamine?

Major depressive illness occurs in almost 7% of the US population during a given year, with a lifetime prevalence of 17%. Despite treatment efforts and interventions, many people with depression fail to respond to treatment, resulting in chronic suffering, functional disability and an increased risk for suicide. It is no wonder that there are constant efforts to find newer and more effective treatments than those which we have available today. New medications reach the market all the time, with the hope that more people will find relief from their suffering. New technologies, such as Transcranial Magnetic Stimulation have become popular, although they have not been proven to be more effective than medication and therapy for the treatment of depression. Lately, there has been a considerable amount of excitement regarding a medication called ketamine, also known by its street name, “Special K”, with the hope that it could be the magic bullet in the search for providing immediate relief for the symptoms of depression and suicidality.

Ketamine is an FDA approved NMDA receptor antagonist that targets the glutamatergic system in the brain. It was first used as an animal and subsequently human tranquilizer during surgeries and medical procedures to prevent the sensation of pain. In recent years, several studies have suggested that the intravenous infusion of ketamine may rapidly reduce depressive and suicidal symptoms. No doubt, this is exciting and promising news. Patients are asking their therapists and doctors how they can get ketamine for themselves or for their family members. Clinicians are suggesting to their clients and patients that they “may want to try ketamine”. Meanwhile, for a high fee, ketamine infusions or injections are being increasingly offered in medical offices and clinics around the country.

Despite the understandable desperation, hopeful enthusiasm and media attention, there is a relative paucity of research. There is an absence of long term treatment trials and outcomes data.
There is a lack of clarity regarding dosage, duration and frequency of administration. Side effects including changes in blood pressure and pulse rate, cardiac arrhythmias and respiratory suppression have been reported. Anxiety, insomnia, confusion, dissociation and hallucinations have also been reported. Dependence and tolerance can develop over time, which is why ketamine is classified as a schedule III controlled substance.

In a recent publication by The APA Council of Research Task Force on Novel Biomarkers and Treatments, the authors concluded that although the immediate positive effects may be profound, they are short lived, with relapses commonly occurring within two weeks after an injection or infusion. The temptation then becomes to continue with repeated injections or infusions; however, this has the potential for cardiac and pulmonary complications, cognitive impairment, neurotoxicity and the risk of dependence and abuse, while the research that would offer guidance in this area has yet to be completed.

The use of ketamine or similar agents may one day have a role in the treatment of depression; however, further research is clearly needed before ketamine is to be used in an office or clinic setting. When ketamine is used during FDA regulated research studies, ketamine is given under the supervision of an anesthesiologist, with close monitoring of vital signs and cardiopulmonary functions to ensure for its safe use. In accordance with the medical principle to “first do no harm”, there is no role for the use of ketamine in clinical practice for the treatment of depression, suicidality or any other mental health condition at the present time. Patients interested in pursuing the potential use of ketamine for their mental health conditions should be directed to see if they may be eligible to participate in FDA regulated ketamine clinical trials in their locale, found by a search on the website ClinicalTrials.gov

References:

Newport, D. Jeffrey, MD, Carpenter, Linda L., MD, et.al., The APA Council of Research Task Force on Novel Biomarkers and Treatments, Ketamine and Other NMDA Antagonists: Early Clinical Trials and Possible Mechanisms in Depression; appl.ajp.2015.15040465

As of October 1, 2015 ICD-10 is LIVE

As of October 1, 2015, Anthem is LIVE with ICD-10 as the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U. S. Department of Health and Human Services (HHS).

Even though October 1, 2015 “go live” date has come and gone, we continue to share information and news with you. In this newsletter make sure to read the articles, “Anthem Blue Cross has implemented ICD-10” and “ICD-10: Splitting bills could cause overpayments”. On our provider website anthem.com/ca, please visit our ICD-10 Updates Web page for other reference material and information.
Provider Network Education 2015 seminars and e-solutions

The Provider Network Education team develops and delivers quality educational programs and materials for the staff of physicians, hospitals, medical groups, ancillary, behavioral health and other health care professionals. Our education programs offer ‘blended learning’, combining face-to-face and web-based opportunities. Our ‘complimentary’ education programs are offered to all contracted providers throughout California.

Seminars

Our fall ‘Contracted Provider Information Exchange’ seminars are interactive and offer tips, process improvements and best practices. Many relevant Anthem Blue Cross business topics are presented. These seminars will be offered in [16] sixteen locations throughout California in October and November.

In the Spotlight section of anthem.com/ca, the link 2015 Provider Education Seminars and Webinars takes you to the Provider Network Education landing page. A collection of provider education tools are available to view and print.

e-Solutions

Web-based learning opportunities are available 24/7/365 from your office and personal computer:

- SEMs – Supplemental Education Materials are available on a variety of Anthem Blue Cross business subjects. These documents will display in pdf format and can be viewed, saved or printed.

- On-Demand e-Courses offer a self-paced instruction environment. Currently there are [3] three e-Courses available for you to take. To register for an e-Course, select the ‘click here’ link on the Provider Network Education landing page.


- Webinar Recordings offer our providers the opportunity to request a copy of a ‘live’ webinar. The [3] three ‘live’ webinar recordings are: 1) BlueCard [Out-of-Area] Refresher, 2) Facility Manual Overview and 3) Behavioral Health Provider Resources- Online Access. Simply send an email request to our shared mailbox: network.education@anthem.com

Questions? We’re available by email, network.education@anthem.com, phone 1-818-234-1016, or fax 1-818-234-8959.

Registration for prescribing of controlled substances: Required by December 31, 2015

CURES 2.0, the updated version of the “Controlled Substance Utilization Review and Evaluation System”, is now active. There is a rollout to present users of Version 1.0 and the California Department of Justice has
mandated that all prescribers and pharmacists apply for CURES access by January 1, 2016. The CURES system is designed to identify and deter drug abuse and diversion through accurate and rapid tracking of Schedule II through IV controlled substances. It is a valuable investigative, preventive and educational tool for law enforcement, regulatory boards, educational researchers, and the health care community.

The CURES Database is available to those who “prescribe, order, administer, furnish, or dispense Schedule II-IV Controlled Substances. CURES contains the following information: patient name, patient date of birth, patient address, prescriber name, prescriber DEA number, pharmacy name, pharmacy license number, date prescription was dispensed, prescription number, drug name, drug quantity and strength, and number of refills remaining.”

Registration is easily accomplished using the online form followed by mail submission of a notarized copy of the Application Confirmation, DEA Certificate, and government issued photo ID. Prescribers will require approved tamper resistant prescription forms.

Introducing Anthem Togetherworks

At Anthem Blue Cross, we look for ways to get results and achieve goals together. Every day we bring our tools, information, and expertise to the table in ways that benefit our members and providers. With this effort, we introduce Anthem Togetherworks – a new name for our provider collaboration strategy. Anthem Togetherworks refers to a broad spectrum of partnership options already in place at Anthem Blue Cross, and includes programs like Enhanced Personal Health Care (EPHC) and the Quality Hospital Incentive Program (QHIP).

Anthem Togetherworks also includes tools we offer, such as our web-based Provider Care Management Solutions and Care Delivery Transformation support. Through Anthem Togetherworks, we’ll continue to offer a wide range of provider collaboration programs and offerings based on your needs, to help us work together to meet the challenges of a new era in health care.

Mobile App to manage cancer symptoms updated to address psychosocial distress

A free mobile app that aims to help people with cancer manage the physical symptoms of the disease has been updated to address the emotional and social stressors of cancer as well. Originally launched in October 2014, the Self-Care During Cancer Treatment app provides strategies for managing the symptoms related to cancer and its treatment. It was developed by Empowerment and Action for Cancer Care, an alliance between Anthem, Inc. and Genentech.

The app, available in the iTunes App Store™ and Google Play™, will now include the Cancer Support Community's CancerSupportSource®, the organization's evidence-based distress screening tool.
“The ability for people with cancer to access tools that can help them manage their emotional wellbeing is another innovative step in helping to close gaps in care for so many individuals who are living with cancer,” said Jennifer Hausman, community health initiatives director at Anthem, Inc. “Self-Care During Cancer Treatment continues to be a tool that empowers individuals to more actively engage in their own health and wellbeing and foster a dialogue with their physician.”

“Screening people for cancer-related distress, defines quality cancer care and yet countless patients are never asked about their distress or given resources for support. This self-care app will provide patients with a tool at their fingertips to identify their worries and concerns and get information. Patients can use their results to talk to their healthcare provider or to reach out to advocacy organizations to find the information and support they need to reduce distress and improve their quality of life,” said Vicki Kennedy, LCSW, CSC vice president of program development and delivery.

**Billing**

**Anthem Blue Cross has implemented ICD-10**

The U.S. Department of Health and Human Services (HHS) mandated October 1, 2015, as the compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

Effective October 1, 2015, Anthem Blue Cross began accepting and processing ICD-10 diagnosis and inpatient procedure codes for claims with dates of service/discharge on or after the October 1, 2015, compliance date. Our systems, supporting business processes, policies and procedures are now compliant with ICD-10.

The [ICD-10 Updates](#) Web page contains reference materials and other information for your use:

- Coding Guidelines for Preauthorization and Claims Submission Reference Chart
- Claims Billing by Service Type Reference Chart
- Link to EDI Edits for ICD-10
- Guidance on paper claims containing ICD-10 codes
- Our Response to the CMS/AMA Announcement on ICD-10 in July 2015
- FAQs with Anthem Blue Cross-specific Information
- Our medical policies and clinical UM guidelines have been updated to include ICD-10 coding.

**Please note** once ICD-10 goes live on October 1, 2015, and providers are ready, these preparation tools and resources will no longer be available on our Web page:

- TIBCO Validator claims file acceptance testing
- Coding Practice Tool for Professional Providers
Effective October 1, 2015, all questions and claims inquiries regarding ICD-10 should be handled as any other questions and claims inquiries are handled today. Contact the Provider Services first. Provider Services has been trained to handle questions on ICD-10 and resolve ICD-10 claims issues.

**ICD-10: Splitting bills could cause overpayments**

Anthem Blue Cross is requiring that outpatient services with dates of service that span from September 30, 2015 to October 1, 2015, are required to be split so services rendered up to September 30, 2015, are filed with ICD-9 codes on one claim and services rendered on/after October 1, 2015, are filed on a separate claim with ICD-10 codes.

However, some provider reimbursement agreements limit the reimbursement amounts for certain outpatient services, such as when combined services are negotiated as a case rate. Splitting the claim could cause these episodes of care to be overpaid. Should you receive any overpayments, here is how you can help resolved these claims quickly.

**Be Proactive** – Should you discover an overpayment for services due to splitting the claim into ICD-9 and ICD-10 coded claims, notify Anthem Blue Cross immediately and refund the overpaid amount back to us.

**Be Responsive** – Anthem Blue Cross will request a refund of any overpayment amounts discovered. Please remit refunds promptly once notified.

Working together, we can resolve these overpayments in a timely manner as we partner for a smooth transition to ICD-10.

**Behavioral Health outpatient coding**

In 2013, the AMA updated behavioral health outpatient CPT codes and issued new coding guidelines for their use. The new guidelines included CPT code 90834, 45-53 minutes face-to-face with the patient, and CPT code 90837, 53-60 minutes with the patient.

Prior to 2013, the psychotherapy “hour” was billed using a code for 45-50 minutes of time with the patient. With the release of the new CPT codes, Anthem has observed that over half of the billing for this type of psychotherapy is now claiming 53-60 minutes spent face-to-face with the patient at each session.

Anthem would like to remind you of specific guidelines per the AMA CPT codebook for commonly billed codes.
If you use an E/M code:

- The type and level of an E/M service is selected based on key components of history, examination and medical decision-making, therefore, time may not be used as the basis of E/M code selection.
- Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy add-on service.

If you use a psychotherapy code which is defined by time:

- Documentation should include the time spent face-to-face with the patient and give specific details to what was done in the session
- The American Psychological Association 2013 guidelines state:

> “When billing a private insurer that does not require authorization for 90837 and has not indicated that this code should be used infrequently, you should bill this code if your session time falls into the 53-minute or more time frame that pertains to 90837. We recommend, however, that you record your exact session start and stop times in your clinical note (for example, 1:02 to 1:57) when billing the new codes, as Medicare providers must do. At any point, a company can ask you for appropriate documentation or explanations. Also be mindful that if you have historically billed a company primarily the 45-50 minute code and switch to primarily using the new 60-minute code, that company may ask you to explain this change.”

As always, Anthem retains the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the AMA’s CPT codebook for further code definitions and details.

**Central nervous system (CNS) assessments**

An education and audit program for central nervous system (CNS) assessments begins later this fall; the purpose of this program is to ensure proper documentation for the services billed.

CNS assessments and/or tests involve the testing of cognitive processes, visual motor responses and abstractive abilities and are accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate useful information for treating and caring for the patient. This includes psychological and aphasia assessments; neuropsychological, and developmental testing; and a neurobehavioral status exam.

Neuropsychological testing uses standard techniques to objectively evaluate behavioral and cognitive abilities of patients by comparing the patient’s results to established normal results. Neuropsychological testing generally involves the use of paper/pencil and mechanical procedures and carries little, if any, risk to the patient.
A complete neuropsychological evaluation includes:

a. review of information from the referral
b. face-to-face evaluation with the patient and/or the family, at which time some screening tests may be done
c. administration of various neuropsychological tests tailored to the patient's condition
d. test scoring and interpretation, which is reviewed with the referring clinician and/or the patient, for example Halstead-Reitan, LURIA, and WAIS-R testing

The Health Plan requires that the medical record documentation for CNS assessments/tests be legible, signed, dated, and contain, at a minimum, the following elements:

a. relevant medical and personal history
b. results of initial evaluation determining the need for testing
c. suspected mental illness and/or neuropsychological abnormality/dysfunction
d. types of testing indicated
e. previous testing (if conducted) by same or different provider and efforts to obtain those results
f. tests administered, scoring, and interpretation
g. time involved for each test performed;
   - when the testing is done over several days, the testing time should be reported all on the last date of service
h. treatment report and recommendations

The time spent in interpreting and preparing the report and any explanation of the report to the patient and family are to be billed with the applicable code used to perform the test.

**Psychological Testing**

*Note: Anthem Blue Cross will only reimburse Psychiatrists and Licensed Psychologists for the following code set.*

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<tr>
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<th>Description</th>
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<tr>
<td>96101</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96103</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report</td>
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Neuropsychological Testing

Note: Anthem Blue Cross will only reimburse Psychiatrists and Licensed Clinical Psychologists Board certified in Neuropsychology for the following code set.

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<td>96105</td>
<td>Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.</td>
</tr>
<tr>
<td>96118</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.</td>
</tr>
<tr>
<td>96119</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.</td>
</tr>
<tr>
<td>96120</td>
<td>Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report.</td>
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As always, Anthem appreciates the care provided to our members. Anthem retains the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed.

Please refer to the AMA’s CPT codebook and Anthem documentation policies to ensure your practice is in compliance with these documentation requirements.

**Anthem Blue Cross cost transparency**

As an Anthem Blue Cross (Anthem) participating provider you may have received our November 2014 or May 2015 correspondence, or read the articles in our June, August, or September Provider Network Update newsletters, regarding Anthem Cost Transparency. We informed you in those letters and articles that in response to consumer demand for transparency in health care costs, Anthem released its first cost transparency tool, *Anthem Care Comparison*, and later its successor, *Estimate Your Costs*, a tool available to members on our anthem.com/ca website, which includes functionality allowing members to estimate their out-of-pocket impact and view the estimated costs for many procedures.
Enclosed with the correspondence was also a summary of the methodology used to generate the cost information housed in the National Consumer Cost Tool (NCCT), the source data used to display costs in Estimate Your Costs. The treatment categories for which costs are displayed and the methodology in determining such costs, are defined by the Blue Cross Blue Shield Association. As indicated in the correspondence, NCCT cost data is updated twice annually; the most recent update completed in May of 2015, and the next update scheduled for this month, November 2015. Please look for further information on this in our Behavioral Health Network Update newsletters posted on anthem.com/ca.

We are pleased to announce that starting with the November 2015 refresh of the transparency costs shown, participating Anthem provider costs will be available for review in a secure section of the AVAILITY provider portal. Authorized representatives of participating facilities and professional practices can login to AVAILITY at availity.com, and register to view the transparency costs for their facility or practice. The transparency costs will be made available to our participating providers no less than 30 days before they become available to our members on anthem.com/ca in the Estimate Your Costs function.

Should you wish to review the methodology outside of AVAILITY, you may request a copy by sending an email request to the Anthem California contract support team at CAContractSupport@anthem.com.

To obtain the date of any future biannual updates (2016 or thereafter) to the cost transparency data on Estimate Your Costs, please review our Provider Network Update newsletters. You will then know the dates to go into AVAILITY to review your cost information, just as you are able to do so this year. To view our Provider Network Update newsletters, go to anthem.com/ca. From the Provider Home page select the Communications tab.

Thank you for your service to our members.

**Electronic claim submission - safe, cost efficient and prevents delays**

**Why submit claims electronically?**

- HIPAA compliant – secure computer-to-computer transfer of information
- Save up to $10.00 per claim by reducing paperwork, manual intervention, postage and form stock
- Transmit 24 hours a day, seven days a week; avoid postal delays
- Electronic claims are faster and more accurate
- Notification and error reports provide receipt of your electronic claim
- Electronic remittance advice is offered to all electronic submitters to allow providers to post payments automatically
- Send electronic attachments
Ways to prevent delays

- Use the Payer ID code: 47198
- If you submit through a clearinghouse or use a software vendor, check with them for the correct value that should be used. Many clearing agencies use proprietary values therefore we do not assign or maintain payer ID codes for other entities, clearinghouses or vendors.
- Correct rendering provider information, including individual provider National Provider Identifier (NPI) and TIN is on the claim(s) before submitting
- Correct member information (Anthem Member ID, name and date of birth) is included on the claim(s).
- Submit original claims to Anthem Blue Cross within 12 months of performed services.

Network

Contracted provider dispute resolution

We have an established dispute resolution mechanism to process and resolve our contracted Behavioral Health provider disputes. Review the ‘Dispute Resolution Process for Contracted Providers’ in the Anthem Blue Cross Professional Manual to make sure you understand the process. To access the Manual, login to ProviderAccess®, scroll down the left-hand side and select, ‘Provider Manuals’. Under the subheading ‘Professional’ select, Anthem Blue Cross Professional Manual.

Quickly access the 'Provider Dispute Resolution Request' online on our provider website under the section Forms on the Behavioral Health Provider Resources Web page.

Find answers to BlueCard® (Out-of-Area) questions

As a participating provider of Anthem Blue Cross, you may render services to patients who belong to other Blue Plans and who travel or live in California. The BlueCard Program lets you conveniently submit claims to Blue Plans, including international Blue Plans, directly to Anthem Blue Cross.

The Blue Card Program Provider Manual describes the advantages of the BlueCard Program, and provides information to make filing claims easy. It offers helpful information about verifying eligibility, obtaining pre-authorizations and who to contact with questions. Access the BlueCard Program Provider Manual online, at anthem.com/ca > Providers > Enter > Communications.
How claims flow through BlueCard®

Below is an example of how claims flow through BlueCard.

1. Member of another Blue Plan receives services from the provider.
2. Provider submits claim to the local Blue Plan.
3. Local Blue Plan recognizes BlueCard member and transmits standard claim format to the member’s Blue Plan.
4. Member’s Blue Plan adjudicates claim according to member’s benefit plan.
5. Member’s Blue Plan issues an EOB to the member.
6. Member’s Blue Plan transmits claim payment disposition to the local Blue Plan.
7. Local Blue Plan pays the provider.

After the member of another Blue Plan receives services from you, you should file the claim with Anthem Blue Cross. We will work with the member’s Plan to process the claim and the member’s Plan will send the explanation of benefit or EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract (Agreement) with you and based on the member’s benefits and coverage.

Submit claims to Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007.

NEW! UC SHIP is going mobile

Beginning August 1, 2015, the University of California Students and their dependents can download the new StudentHealth app through Anthem Blue Cross.

Using their smartphone or tablet they can quickly and easily access UC SHIP, including:

- Their UC SHIP member ID card
- Student Health Services (SHS) - location, hours, services
- A description of their UC SHIP plan benefits
- Anthem Blue Cross - for medical claims and other plan benefits
- myCatamaranRx - to manage their prescriptions
They just download the StudentHealth app from the Apple App Store™ or Google Play™, and in a few minutes they are on their way.

Updates to Anthem Blue Cross' “Find a Doctor” tool

Find a Doctor tool at Anthem Blue Cross (Anthem) is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To ensure Anthem has the most current and accurate information, please take a moment to access the Provider Finder tool at anthem.com/ca and review how you and your practice are being displayed. Report discrepancies to Anthem by sending an email to ProviderDatabaseAnthem@anthem.com

Resource corner – Contracted providers get answers to everyday Behavioral Health topics

Availity Web Portal (Availity) is your online resource to verify benefits and eligibility or claim status. Register now at availity.com to access today!

Balance billing for covered services is not allowed for Anthem Blue Cross members according to your Participating Mental Health Practitioner Agreement (Agreement).

Behavioral Health Provider Relations assists you with questions about your fee schedule, Agreement language or requirements as specified in the Anthem Blue Cross Professional Manual. They can be reached by email at BHNetworks@anthem.com

Behavioral Health Provider Resources is a comprehensive Web page that connects you to behavioral health tools and information. Go online to anthem.com/ca > Providers > Enter > Learn More > Behavioral Health Provider Resources.

CAQH impacts recredentialing. Our Credentialing Program reviews your credentialing data every three years, unless otherwise required by contract or state regulations. You’ll be notified about six months before the three year mark and it’s important that your practice information is current to receive notification.

Login to CAQH and make sure your online application is current. Attest every four months to avoid network participation interruptions due to outdated information (office or mailing addresses, current liability coverage, etc.) For questions, email the CAQH Help Desk at cagh.updhelp@acgs.com or call 1-888-599-1771 toll free.
Claim Submission information can be found in the article “Electronic claims submission - safe, cost efficient and prevents delays” in this newsletter.

Collect copayment or coinsurance from the member and bill Anthem Blue Cross directly for your services.

Copy the member’s identification card (ID) front and back. Always make sure you have the current ID card because plans can and do change.

Questions about a claim can be asked online through the Availity Web Portal or by calling Customer Service number on the back of the member’s ID card.

Send a detailed question to clarify the status of a claim or to get additional information on a claim. Secure Messaging is feature for our providers that is accessed at availity.com. This functionality is only available on the Availity Web Portal. Secure messages can be sent for local Anthem Blue Cross, Anthem Blue Cross Blue Shield (Anthem), BlueCard® out-of-area, and FEP (Federal Employee Program) member claims.

When calling Customer Service make sure to have the member’s ID number, claim number and claim reference number (also called DCN). Ask for a supervisor if needed to resolve your issue.

Rate information is available online in our secure portal, ProviderAccess®. Enter your login information, scroll down the left-hand side of the page to, “What’s New” and select Mental Health Practitioner Fee Schedule Update. Don’t have a ProviderAccess account? It’s easy to register online today!

Refer in-network to participating or in-network Anthem Blue Cross providers in all circumstances, except when authorization has been granted in advance by Anthem Blue Cross Utilization Management to refer to a non-participating provider.

Verify benefits and eligibility to determine coverage and whether authorization is needed, co-pay and where to send the claims before rendering any services.

Practice information is important and it’s easy to update

Practice information helps us direct referrals and members who access care directly. To keep our online provider directories up-to-date, it is important that your information (e.g. practice address, areas of expertise, etc.), is accurate. To prevent member servicing delays notify us within 10 business days of practice changes. The Practice Update Form and the Practice Profile are convenient online options for updating your practice information.

Use the Practice Update Form to change the following information:

- Email address
- Check/EOB/Billing/ Reimbursement address
- Mailing/Correspondence address
Psychiatric Mental Health Nurse Practitioners are in demand

If you’re a supervising Psychiatrist interested in your Psychiatric Mental Health Nurse Practitioner participating in the Anthem Blue Cross Behavioral Health Network, request participation online. Visit the Anthem Blue Cross Provider website, “Join Our Networks” or follow the path [anthem.com/ca > Providers > Enter > Behavioral Health Provider Resources > Request Participation to be a Network Provider](#).

Sign-up now for our Network eUPDATE today – it’s free!

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our Network eUPDATES.

Network eUPDATE is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates
- System changes
- Fee Schedules
- Medical policy updates
- Claims and billing updates
- …and much more

Registration is fast and easy. There is no limit to the number of subscribers who can register for Network eUPDATES, so you can submit as many email addresses as you like.
Anthem EAP is opening the Network to more California (CA) providers!

Anthem Employee Assistance Program (EAP) is now accepting applications to join the EAP from all participating CA Behavioral Health Providers. Go to [Anthem EAP](https://www.anthem.com) > Providers > scroll to Panel Consideration and follow the instructions to request an application.

**Misrouted protected health information (PHI)**

Providers and facilities are required to review all member information received from Anthem Blue Cross to help ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact an Anthem Blue Cross provider services area to report receipt of misrouted PHI.

**Members’ rights and responsibilities**

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating providers and members (our members, your patients) in our system, Anthem Blue Cross has adopted a Members’ Rights and Responsibilities statement. You can find the statement on our provider website. To access online go to [anthem.com/ca](https://www.anthem.com/ca) > Providers > Enter > Health & Wellness > Quality Improvement and Standards > Member Rights & Responsibilities.

**Network leasing arrangements**

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call “Other Payors”. Other Payors and affiliates use the Anthem Blue Cross network.

Under the terms of your provider contract, members of Other Payors and Affiliates are treated like Anthem Blue Cross members. As such, they’re entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. You can obtain the Other Payors list on [ProviderAccess®](https://www.anthem.com/antheمحا). If you have questions or don’t have Internet access, Behavioral Health Provider Relations can assist by email at [BHNetworks@anthem.com](mailto:BHNetworks@anthem.com)
Guidelines and Quality Programs

Contract Compliance with Accessibility Standards for Emergency Care Instructions and After Hours Care

As you know, Anthem Blue Cross monitors member access to Behavioral Health care through a number of mechanisms, including provider and member surveys. These surveys are conducted by the Industry Collaborative Effort (ICE) After Hours team, North American Testing Organization (NATO), Experience of Care and Health Outcomes (ECHO™) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.

In surveying compliance with After Hours standards, participating providers' offices are called outside of normal business hours to determine if callers are given appropriate emergency instructions, and have a mechanism to reach a provider after regular hours for urgent situations. Members who have received behavioral health care within the previous year are also surveyed via mail. The surveys, in addition to monitoring member complaints, help us to identify whether access to care is available to our members after or before normal business hours.

The key to our 2015 success is...YOU!

We thank those of you who have already taken steps to comply with the standards. Your efforts make a direct positive impact on the level of service and access to care for our members. We need your continued partnership and commitment in helping us achieve the best results possible for our 2015 surveys, which will be conducted over the next few months.

In an effort to improve our results for 2015, Anthem Blue Cross is sharing the 2014 results below.

ECHO Member Experience Survey 2014

<table>
<thead>
<tr>
<th>Question</th>
<th>Result (% who answered “yes”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got help or advice when calling after regular office hours</td>
<td>65.7%</td>
</tr>
</tbody>
</table>
ICE Provider After Hours Survey 2014

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>“What would you tell a caller who states he/she is dealing with a life-threatening emergency?” (Compliant Answers: Hang up and Dial 911 or go to the nearest emergency room; go to nearest emergency room; or Hang up and Dial 911)</td>
</tr>
<tr>
<td>Medical: 83.1%</td>
</tr>
<tr>
<td>Behavioral Health: 78.5%</td>
</tr>
<tr>
<td>Urgent Request After Hours. “In what time frame can the patient expect to hear from the provider or on-call provider?” Note: Providers are expected to provide a specific timeframe in that a member can expect a return call. If a specific timeframe is not provided, the answer is considered “non-compliant.”</td>
</tr>
<tr>
<td>Medical: 78.2%</td>
</tr>
<tr>
<td>Behavioral Health: 71.0%</td>
</tr>
</tbody>
</table>

How Can You Make a Difference?

- Review *Anthem Blue Cross Access Standards* under the **Rights and Responsibilities** and **Quality Improvement** sections of your *Anthem Blue Cross Professional Manual*. Make sure your practice policy and procedures comply with the standards.
- Ensure your After Hours office staff, answering service and/or answering machine message specifically inform callers when their urgent (non-emergent) calls will be returned.
- Ensure your After Hours office staff, answering service and/or answering machine message directs callers to dial 911 or go to the nearest emergency room if they believe they are experiencing an emergency.

If your office was surveyed in 2014 and found non-compliant with these After Hours requirements, you will receive a letter with recommended compliance measures to ensure prompt changes are made prior to the commencement of the 2015 After Hours surveys.

We value your participation in the Anthem Blue Cross Behavioral Health Network, and appreciate your efforts to partner with us in meeting compliance with established access standards. If you have questions, please email our Behavioral Health Provider Relations team at **BHNetworks@anthem.com**.

**Timely Access Regulations**

Anthem Blue Cross is committed to keeping you, our network partners, updated on our activities related to our compliance with the Department of Managed Health Care (DMHC) Timely Access to Non-Emergency Health Care Services Regulations (the “Timely Access Regulations”). Anthem Blue Cross maintains policies, procedures, and systems necessary to ensure compliance with the requirements of 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 can only achieve this compliance with the help of our provider network partners, you!

There are many activities that are conducted to support compliance with the regulations and we need you, as well as covered individuals, to help us obtain the information that is needed. Some of these studies are sponsored by the Industry Collaborative Effort (ICE), allowing for consistency across Health Plans. These studies allow our Plan to determine compliance with the regulations.

The activities include, but are not limited to the following:

- ICE Provider Appointment Availability Survey
- ICE Provider Satisfaction Survey
- ICE Provider After – Hours Survey

These surveys are currently in process. Please inform your office staff so they are prepared and understand the importance of each providers’ participation in each of the surveys.

We appreciate that in certain circumstances time-elapsed requirements may not be met. The Timely Access Regulations have provided exceptions to the time-elapsed standards to address these situations:

**Extending Appointment Wait Time:** The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

**Preventive Care Services and Periodic Follow-Up Care:** Preventive care services and periodic follow-up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

**Advanced Access:** The primary care appointment availability standard may be met if the primary care physician office provides “advanced access.” “Advanced access” means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician’s assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

We hope this clarifies Anthem’s expectations and your obligations regarding compliance with the Timely Access Regulations. Our goal is to partner with our providers to successfully meet the expectations for the requirements in the most efficient and patient-friendly manner possible.
### Access Standards for Behavioral Health and EAP Practitioners

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Care Instructions</strong></td>
<td>Members are directed to 911 or the nearest emergency room.</td>
</tr>
<tr>
<td><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></td>
</tr>
</tbody>
</table>

| Non-Life Threatening Emergency Care              | 6 hours                                                                  |
| U Urgent Care *(does not require* prior authorization) | 48 hours                                                               |
| U Urgent Care *(requires* prior authorization)  | 96 hours                                                                |
| Routine Office Visit/Non-urgent Appointment      | 15 Business days *(Psychiatrists)*  
|                                                 | 10 Business days *(Non-Physician Mental Health Care Providers)*  
|                                                 | 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 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                     | Usually members do not have to wait longer than fifteen (15) minutes after their scheduled appointment to see a Behavioral Health/EAP provider. |
Covered Individuals also have access to Anthem Blue Cross' 24/7 NurseLine. The phone number is located on the back of their health care ID card. In addition, Covered Individuals and Providers have access to Anthem Blue Cross’ Customer Service team at the telephone number listed on the back of the covered individual's health care ID card. A representative may be reached within 10 minutes during normal business hours.

If you have questions, please contact our Behavioral Health Provider Relations team by email at BHNetworks@anthem.com

For additional information about the regulations, please visit the Department of Managed Health Care’s website at dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessstoCare.aspx

Clinical practice and preventive health guidelines available on the web

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.

To access the guidelines online, go to anthem.com/ca > Providers > Enter > Health & Wellness > Practice Guidelines.

Medicare Advantage Updates

The Medicare Advantage Program is included under your Anthem Blue Cross Participating Mental Health Practitioner Agreement. Email Behavioral Health Provider Relations at BHNetworks@anthem.com if you have questions about your participation status.

Keep up with Medicare Advantage news

Please continue to check Important Medicare Advantage Updates at anthem.com/ca/medicareprovider for the latest Medicare Advantage information.

Precertification requirements updated for 2016

Please refer to your provider agreement, Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem Blue Cross provider home page at anthem.com/ca for further information on existing precertification requirements and new precertification requirements for 2016. Non-contracted providers should contact the Health Plan. Anthem Blue Cross Cal MediConnect
Plan providers can get related information in your Provider Manual. Access your provider manual online at anthem.com/ca > Providers > Enter > Plans & Benefits > Anthem Blue Cross Cal MediConnect Plan > Provider Manual.

**Medi-Cal Managed Care Updates**

Participation in the Behavioral Health Medi-Cal Network is covered by a different Agreement and payment schedule than the Agreement for the Commercial Behavioral Health Network, which includes but is not limited to Commercial PPO, HMO, plans on the Marketplace (HMO, PPO, and EPO) and Medicare Advantage Plans. Email Behavioral Health Provider Relations at BHNetworks@anthem.com if you’re unsure about your status in the Medi-Cal Behavioral Health Network.

**Provider self-service tools make it easy to do business**

The provider self-service web portal offers 24/7 access to simple to use tools - making it easier than ever to get information. Read more for benefits and access.

**ICD-10 documentation and diagnosis coding tips**

This handy reference sheet puts ICD-10 formatting, structure, official outpatient services guidelines, documentation concepts and more, right at your fingertips. Get the coding tips reference sheet here.

**Behavioral health authorization requirement changes**

Anthem Blue Cross has recently updated our Precertification Lookup Tool (PLUTO) to more accurately reflect the current behavioral health authorization process for our Medicaid products. As a result of this update, effective November 1, 2015, PLUTO has been updated to show that authorization is required for psychological and neuropsychological testing for both medical and behavioral health purposes. Access the code changes and service descriptions.

**Medical Policies and Clinical Utilization Management guidelines update**

The Medical Policy and Technology Assessment Committee (MPTAC) approved Anthem Blue Cross medical policies and Clinical Utilization Management (UM) Guidelines, developed or revised to support clinical coding edits for Medi-Cal Managed Care members. These approved medical policies and Clinical UM Guidelines are publicly available on the MediCal provider website.
Anthem Blue Cross Cal MediConnect Plan Update

This section of the newsletter addresses information about the Medicare-Medicaid Plan or MMP. Members are enrolled in both Medicare and Medicaid under the Anthem Blue Cross Cal MediConnect Plan.

Quality Improvement program announcement

Our focus at Anthem Blue Cross Cal MediConnect Plan is helping our members stay healthy through quality medical care. Each year we look closely at the medical care programs we use to measure our quality. The results tell us what is working best to help improve our members' health and what we should change. This process is called the Quality Improvement (QI) program. The QI program and its goals help us support our provider network in delivering quality care to our members.

Use this link to read about the Quality Improvement program and expectations.