Anthem Blue Cross will soon contract with Psychiatric Mental Health Nurse Practitioners who offer Evaluation and Management services (formerly medication management). We are on track to complete activities by the end of the year. Supervising Psychiatrists that have an interest in their Psychiatric Mental Health Nurse Practitioners participating with Anthem Blue Cross, may send a letter of interest to us.

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CPT code changes that impact Behavioral Health screening and testing codes for Applied Behavior Analysis

The American Medical Association (AMA) has established new Current Procedural Terminology (CPT®) codes for Applied Behavior Analysis (ABA). Based on those CPT code changes we notified impacted contracted providers about the change in December. The specific provider types included: ABA, psychologists and neuropsychologists. The update impacted their existing Anthem Blue Cross Participating Mental Health Practitioner Agreement (Agreement) Exhibit B, Applied Behavioral Analysis Payment Schedule. These changes take effect on January 1, 2019.

IMPORTANT

- There isn’t necessarily a one-to-one cross-walk between new and deleted codes.
- Time definitions have changed.
- Use current codes for service dates up until December 31, 2018.
- Only use new codes for service dates beginning on or after January 1, 2019.
- Anthem Blue Cross is updating all authorizations to reflect new codes for service dates on or after January 1, 2019.
- Claims submitted with new codes for service dates prior to January 1, 2019, or deleted codes on or after January 1, 2019 will be denied.

If you have general questions about the transition from 2018 to 2019 CPT codes, the fee schedule or your Agreement, email our commercial Behavioral Health Network Relations team at CABHNetworkRelations@anthem.com. For specific information and descriptions, refer to the 2019 CPT® Manual.

Behavioral Health related clinical UM guidelines

An important update to Anthem Blue Cross Behavioral Health related Medical Policies and Clinical UM Guidelines was mailed December 14, 2018 to the entire Behavioral Health Network. The letter highlighted changes effective March 15, 2019. Please refer to the specific policy for coding, language, and rationale updates and changes.

View Medical Policies, Clinical UM Guidelines and customizations to MCG Care Guidelines on our public website at anthem.com/ca. Select the tab, Providers at the top of the page > Policies and Guidelines > scroll the page to View Medical Policies & Guidelines > Medical Policies and Clinical UM Guidelines (for Local Plan members), at the bottom of the page, select Continue.
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The Behavioral Health Utilization Review and Care Management staff use these Guidelines to determine if the requested treatment is medically necessary as defined in the member’s Evidence of Coverage (EOC).

If you have questions about Anthem Blue Cross Behavioral Health related Medical Policies and Clinical UM Guidelines call the Utilization Management Department toll-free at 1-800-274-7767 and select the option for Behavioral Health.

Who is Availity?

Anthem Blue Cross (Anthem) has partnered with the Availity Portal (Availity) to operate and service the entry point for all EDI submissions to Anthem, otherwise known as the EDI Gateway.

Most of you know Availity as a secure website (portal) or claims clearinghouse, but they are much more. Availity is also an intelligent EDI Gateway for multiple vendors and will be the EDI connection for all Anthem Inc. and its affiliates.

If you currently use a clearinghouse, billing company or if you submit directly, all your EDI transactions will flow through the Availity EDI Gateway to Anthem.

How are you submitting EDI transactions today?

- If you currently transmit your EDI Submissions using a clearinghouse or billing company, you should contact your clearinghouse to confirm your EDI submission path has not changed. If you are notified of any potential impacts with connectivity, workflow or financial, please know there is no cost alternate submission options available with Availity.
- If you currently submit directly to Anthem and already have an Availity login for the portal, you can use that same login for your EDI services.
- Visit apps.availity.com/web/welcome/#/anthem to learn more.

How can you directly transmit EDI submission to Availity?

Below are the different ways you can submit direct EDI transactions to Availity:

- **Submit transaction files through FTP** - If you work with a practice management system, health information system, or other automated system that supports an FTP connection, you can securely upload EDI transactions to the Availity FTP site where they are automatically picked up by Availity and submitted to Anthem Blue Cross (Anthem)

- **Submit transaction files through Availity** - If you have batch files of EDI transactions that you need to process and you choose not to use the Availity FTP site, you can manually upload the batch files through Availity.
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**Submit transactions through manual data entry in Availity** – Availity makes it easy to submit transactions, such as eligibility and benefits inquiries or claims, by entering data into our user-friendly web forms.

**What are your next steps?**

- We recommend that you register with Availity for your EDI transmissions and begin migrating your volume as soon as possible.
- Availity will be working directly with your clearinghouse, billing companies and if you choose to submit directly- your organization.

If you have any questions, call Availity Client Services toll-free at **1-800-Availity (1-800-282-4548)** Monday through Friday 5 a.m. to 4:30 p.m. PT.

**Availity EDI gateway webinars scheduled**

Great news! Anthem, Inc. and our affiliates now use Availity as our designated EDI service. If you currently use a clearinghouse, billing company, or if you submit directly, all your EDI transactions will flow through the Availity EDI Gateway to Anthem.

Check out an upcoming webinar for lots of great information to get you started. At the end, of the session, you can participate in a live Q&A session. During this fast paced hour, learn how to:

- Understand Availity's EDI Gateway and Clearinghouse workflow for:
  - 837 – Institutional
  - 837 – Professional
  - 837 – Dental
  - 835 – Electronic Remittance Advice
  - 276/277 – Claim Status – real-time
  - 270/271 – Eligibility – real-time

- Enroll for and manage 835 ERA delivery with Availity
- Use Availity to manage file transfers, set up EDI reporting preferences, and more.
- Access and navigate the Availity EDI Guide
- ...and more.
Upcoming webinar sessions:

- Wednesday, January 16, 2019 11 a.m. to noon PT
- Thursday, February 7, 2019 11 a.m. to noon PT
- Tuesday, March 5, 2019 noon to 1:00 p.m. PT

It’s easy to enroll:

- Log in to the Availity portal.
- Click Help & Training | Get Trained
- In the Catalog, select Sessions
- Scroll through Your Calendar to view upcoming live events

Missed a session? We’ve got you covered with a recording of a previous live session. In the Availity Learning Center (ALC), search the Catalog by keyword, “song” and enroll for the on-demand option.

Need Help? Email training@availity.com if you have issues enrolling for a live webinar.

Use Interactive Care Reviewer to submit online authorization requests

Improve the efficiency of your preauthorization process by submitting your Anthem inpatient and outpatient (when required) behavioral health and ABA requests using our online authorization tool, the Interactive Care Reviewer (ICR). Access to ICR is available exclusively on Availity.

Begin using ICR today and discover all the great benefits you will gain by submitting your authorizations online.

Time savings

- Reduce and practically eliminate the need to fax or phone in your requests
- No time spent waiting on hold. Save an average of 15 minutes per case compared to fax or phone
- Precertification requests are accessible in one place, at any time by you or designated staff

Ease of use and improved efficiency

- No need to fax! Reduced paperwork!
- The ICR dashboard lists current status of your requests
- Track status on cases submitted via phone or fax
- Attach and submit clinical notes and supporting images
- Proactive contact via email updates
- View and print case determination letters
Automated responses

- ICR is able to provide a decision on whether an authorization is required
- For some procedures, ICR is able to deliver immediate decisions

Is it your first time using ICR on Availity?

You or your designated Availity Administrator can assign the “Authorization and Referral Request” role to those you allow. The role assignment gives immediate access to ICR. Just log onto Availity, select Patient Registration > Authorizations & Referrals > Authorizations.

Need training?

Check out our ICR Help Page for learning tools, and on Availity, select Payer Spaces > Education and Reference Center for educational resources.

Anthem Blue Cross works to simplify payment recovery process for National Accounts membership

In Anthem Blue Cross’ (Anthem) ongoing efforts to streamline and simplify our payment recovery process, we continue to consolidate our internal systems and will begin transitioning our National Accounts membership to a central system in 2019. While this is not a new process, we are transitioning the National Accounts membership to align with the payment recovery process across our other lines of business.

Currently, our recovery process for National Accounts membership is reflected in the EDI PLB segment on the electronic remittance advice (835). This segment will show the negative balance associated with the member account number. Monetary amounts are displayed at the time of the recovery adjustment.

As National Accounts membership transitions to the new system and claims are adjusted for recovery, the negative balances due to recovery are held for 49 days to allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remits only within the “Deferred Negative Balance” sections.

After 49 days, the negative balances due are reflected within the 835 as a corrected and reversed claim in PLB segments.

For any questions or concerns, please call the E- Solutions Service Desk toll-free at 1-800-470-9630.
Health Care Reform Updates (including Health Insurance Exchange)

We invite you to visit our provider website to learn about the many ways health care reform and health insurance exchange may impact you. New information is added regularly. View the latest articles on health care reform and health insurance exchange and all archive articles too.

Go to the anthem.com/ca Provider Home page, select Health Care Reform Updates and Notifications or Health Insurance Exchange Information.

Individual on and off exchange plans – 2019 benefit year update

For the 2019 benefit year, Anthem Blue Cross (Anthem) will continue to offer EPO Individual on-exchange and off-exchange plans in Covered California’s service counties listed below under the subsection, “Counties”. As in 2018, for all other regions not listed, Anthem will not be offering Individual health plans in 2019.

Counties

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba, Santa Clara, Mariposa, Merced, San Juaquin, Stanislaus, Tulare.

Member explanation of benefits gets a makeover

By the end of 2018, Anthem members will begin receiving a new explanation of benefits (EOB) that is designed to help members better understand their health care benefits and out-of-pocket expenses. The new design will look more like a health care summary. EOBs will continue to include important information about services rendered, the amount paid to the provider, and the member out-of-pocket expense.

The new EOB will also include:

- Ways members can save on health care expenses
- A preventive care checklist, sharing important screenings that were missed
- A summary of the member’s most recent claims
Anthem’s online provider directory

Our “Find a Doctor” tool, commonly known as Provider Finder, is used by consumers, members, brokers, and providers to identify in-network (contracted) health care providers supporting member health plans. Take a moment to access Provider Finder at anthem.com/ca and make sure your practice information is accurate.

To access the Anthem Blue Cross online directory, our Provider Finder, follow the navigational instructions below.

1. Go online to anthem.com/ca.
2. Select the Providers option from the top navigation.
3. Another navigation pane opens. Select, Find a Doctor
4. A new window will open. Scroll down to Search as a Guest, then select the link, Search by All Plans and Networks
5. A new window will open. Enter information in the fields.
6. Results display. Email, download and save, or print.

Provider data updates

It is extremely important that we have accurate and up-to-date information about your practice in our directories. Senate Bill 137 (SB 137), which went into effect last year, requires that Anthem provide our members accurate and up-to-date provider directory data. As a result, Anthem conducts semi-annual outreaches to confirm the information we have on file is accurate. Without verification from you that our provider directory information is accurate, we will be required to remove your practice from the directories we make available to our members. If you have questions about updating your practice email the Behavioral Health Network Relations team at CABHNetworkRelations@anthem.com.

Follow steps listed below to submit practice changes:

1. Use the Practice Update Form to report your changes. Note: Tax ID changes require a W-9 form.
2. Send practice changes, additions or deletions to our Provider Database Management team.
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3. Email the form to ProviderDatabaseAnthem@anthem.com with the words, “BH CHANGE” in your subject line.

Detailed information about submitting practice changes can be found in our Behavioral Health Guides for Contracted Providers. A new option to submit changes is the Provider Maintenance Form.

Practice status - open or closed
Prompt written notice of a closed practice prevents member servicing delays. Are you accepting new patients? Your practice status - open or closed must be reflected accurately in our provider directories. California law requires that participating health care providers notify health plans within five days when their “Accepting New Patients” status changes.

Refer to the Anthem Blue Cross Manual (Manual) for time frames and information about reporting your practice status.

Provider Education seminars, webinars, workshops and more!
Our Provider Network Education team offers quality complimentary educational programs and materials specially designed for our providers. For a complete listing of our workshops, seminars, webinars and job aids, go the Anthem Blue Cross website: anthem.com/ca. Scroll down the page to Partners in Health, select Tools for Providers. In the middle of the page select the dark orange box, Finding Resources for California. From the Answers@Anthem page select the link titled, Provider Education Seminars and Webinars.

Sign-up now for our Network eUPDATE today at no charge!
Connecting with Anthem Blue Cross and staying informed is 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
- Claims and billing updates
- ...and much more

Registration is simple 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.
**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 network. Under the terms of your Agreement, members of these other payors and affiliates may access the Anthem provider network. As such, they are entitled to the same Anthem billing considerations, including discounts and freedom from balance billing.

An online list of these other payors is available via Availity.

1. Login to availity.com.
2. Find the *Payer Spaces* tab, and select *Anthem Blue Cross* from the drop-down menu.
3. Choose *Education and Reference Center*.
4. A new window will open. **Select Administrative Support**.
5. The list of documents displays. **Select Network Leasing Arrangements**.

**Behavioral Health Network Relations teams aren’t the same – where to go with questions**

Behavioral Health providers can be contracted under three different types of Agreements: Commercial Behavioral Health, Medi-Cal Behavioral Health and the Employee Assistance Program (EAP). It’s important to understand that you might be contracted with one, two or all three Agreements as a participating network provider, and that each Agreement is different, has a specific fee schedule and a dedicated operational area to answer your unique Network questions.

Network Relations answers questions about the fee schedule, Agreement (contract) language or requirements as specified in the Manual. Each network has a devoted Network Relations team to service specific needs.

We’ve listed the contact information for each team below.

- Commercial Behavioral Health - [CABHNetworkRelations@anthem.com](mailto:CABHNetworkRelations@anthem.com)
- Medi-Cal Behavioral Health - [BHMedi-CalNetworkRelations@anthem.com](mailto:BHMedi-CalNetworkRelations@anthem.com)
- EAP - [EAPPProviderNetworks@anthem.com](mailto:EAPPProviderNetworks@anthem.com)
Contracted behavioral health groups have an email box for group adds

We introduced a new email in June 2018 that will provide focused attention on our existing groups. Email all requests to add a provider to an existing Anthem Blue Cross Participating Behavioral Health Group Agreement (contract) to mailbox: CABHGroups@anthem.com. Make sure your email subject line includes these three things: The words, “Add to group”, your group name and the primary county served. If the text format isn’t followed, unfortunately, your email will be rejected.

Again, this email is only for contracted groups wanting to add a provider(s) to an existing contract. You may also request status on a group add by including specific text in the email subject line. Include the following three things in your subject line: The words, “Add to group status”, your group name and the primary county served. If the text format isn’t followed, unfortunately, your email will be rejected.

Delete the mailbox: CABHContracting@anthem.com to prevent delays of your group add requests or status of such requests. The reason for the change is to make sure your email requests get to the correct area for processing. We have a dedicated team to service your group add needs and we’re excited about that. Please share this information with office staff timely to avoid delays.

Email questions not related to the group add process to: CABHNetworkRelations@anthem.com. Our commercial Behavioral Health Network Relations team answers contractual or procedural questions related to reimbursement, contract language or requirements as specified in the Manual. Only email Behavioral Health Network Relations questions to this team. Immediately delete any other email address you might have on file for California Behavioral Health Network Relations except, CABHNetworkRelations@anthem.com.

Another resource for questions is our Behavioral Health Group Guide, which provides 24/7 access to answers and information on how to do business with Anthem. You’re encouraged to review the document in its entirety with staff. It’s important that you revisit the section, Adding Providers. If all required documents are not submitted in the formats outlined in the guide (Excel or PDF), and if the email subject line doesn’t comply with text requirements, your request cannot be processed.

As we continue to make changes that improve how we do business with you, we’ll communicate them. Our goal is to add providers to your group timely and efficiently to avoid member access to care delays. We feel strongly that this improvement does that!
Anthem Blue Cross’ provider website continues to improve

At the beginning of this year, Anthem Blue Cross (Anthem) launched a new landing page with more intuitive access to key provider resources, allowing you to more easily find what you are looking for. Our website, which include a cleaner and more up-to-date look and feel has received positive provider feedback about these improvements. We continued with improvements mid-year to include an automatic state detection feature allowing you to quickly navigate to state-specific information. We look forward to sharing more updates in 2019!

Misrouted protected health information

Providers and facilities are required to review all member information received from Anthem to help ensure no misrouted protected health insurance (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 Anthem to report receipt of misrouted PHI.

Member 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 (your patients) in our system, Anthem has adopted a Members’ Rights and Responsibilities statement. You can find the statement on anthem.com/ca under Providers | Providers Overview. In the middle of the page select the dark orange box, Finding Resources for California. A new window opens, select the tab Health & Wellness > Quality Improvement and Standards > Member Rights & Responsibilities.

Special Investigations Unit updates

The Special Investigations Unit (SIU) is tasked to conduct investigations involving allegations of fraud, waste and abuse, to work with our providers to resolve billing practice issues in order to reduce or eliminate future payment issue and where appropriate, to recover overpayments.

As part of Anthem’s role to safeguard our members and provide relevant information to providers we
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are relaying the following recent Food and Drug Administration (FDA) warning letter:

**Xtampza** - On February 9, 2018, the Food and Drug Administration issued a letter of warning to Collegium Pharmaceuticals for publicly providing false or misleading representations regarding Xtampza (oxycodone) ER because it “fails to adequately communicate information about the serious risks associated with Xtampza ER use”.

Further details regarding this warning letter from the FDA can be obtained [here](#):

# Products & Programs

**Understanding the Anthem Blue Cross Language Assistance Program**

No interpreter? No problem. Anthem Blue Cross (Anthem) wants you to be able to communicate with your patients clearly and accurately.

- It’s easy
- No cost
- No advance notice required
- All languages

For Anthem members whose primary language isn’t English, we offer at no cost, language assistance services through interpreters. Members have access to interpreters over the phone or face to face during appointments. If the member is interested in these services, please have them call the Anthem Member Services number on their member ID card (TTY/TDD: 711) between 8 a.m. to 5 p.m. Monday through Friday. After regular business hours, telephonic interpreter services are available through the 24/7 NurseLine. To access an interpreter on behalf of your patient, call toll-free 1-800-677—6999.

Please remember, in accordance with the California Language Assistance Program, inform patients of the availability of Anthem interpreter services. You must also document a member’s refusal of any needed interpreter services in his or her patient chart. Make sure to let your patients know that Anthem’s Customer Service Representatives are available to help coordinate appointment scheduling through the interpreter services.

Here’s what to expect:

**Telephone Interpreters**

1. Give the customer care associate the member’s ID number.
2. Explain the need for an interpreter and state the language.
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Face-to-Face Interpreters Including Sign Language

Members can request to have an interpreter assist at a doctor’s office. This request may be made in advance, or when the member is in the office. Doctors may make these requests on behalf of members. Seventy-two business hours are required to schedule services, and 24 business hours are required to cancel.

Please refer to the Manual for additional information on the Language Assistance Program.

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.

Note: EAP is a separate Agreement than a Commercial Behavioral Health Agreement.

For questions about EAP, visit the Anthem EAP website or e-mail EAP Provider Network Services at EAPProviderNetworks@anthem.com. Go to Anthem EAP > Providers > scroll to Panel Consideration to request an application.

Workers’ Compensation acknowledgments required

As a reminder, the “MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN.” (California Code of Regulations §9767.5.1, Medical Provider Networks [MPN])

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem’s Provider Affirmation Portal, go to Availity and login. From the Payer Spaces drop down menu in the top right hand corner, select Anthem Blue Cross from the options available to you. On the next page, select Resources in the middle of the page and look for MPN Provider Affirmation Portal.

If you can't go online, call Anthem Workers’ Compensation toll-free at 1-866-700-2168 and we'll take action on your behalf. Keep an eye out for email notifications from “Anthem MPN Admin.” Note: the Provider Affirmation Portal will also notify participating providers when an MPN is terminating its relationship with Anthem and/or the Division of Workers Compensation.
Pharmacy information available on anthem.com/ca

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit our website, anthem.com/ca/pharmacyinformation. The commercial drug list is reviewed and updates are posted to the website in January, April, July and October.

To locate “Marketplace Select Formulary” and pharmacy information, go to Customer Support, select your state, Download Forms and choose “Select Drug List.” This drug list is also reviewed and updated as needed.

Access FEP Pharmacy updates and other pharmacy related information at fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the Federal Employee Program. You can view the Specialty Drug List or call us toll-free at 1-888-346-3731 for more information.

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

Get help navigating the program and information about claim filing, eligibility, preauthorization and contact information in the Blue Card® Program Provider Manual.

Supplemental Education Materials (SEM) are reference tools and we have a few specific to BlueCard: SEM#10-BlueCard (Out-of-Area) and SEM#32 – BCBS BlueCard Claims Filing. Each provides helpful tips to improve your claim experience, facts about ID cards and much more to explore.

Identify BlueCard members

When members from Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out-of-area members is the alpha prefix. The three-character alpha prefix at the beginning of the member’s identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient’s membership and coverage.

- The ID cards may also have:
  - PPO in a suitcase logo, for eligible PPO members
  - PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
  - Blank suitcase logo
Verify BlueCard member eligibility and coverage

- For Anthem Blue Cross members, visit our website at anthem.com/ca
- Other Blue Plans: contact Anthem Blue Cross electronically or through Availity at availity.com
- Call BlueCard Eligibility toll-free at 1-800-676-BLUE (2583) to verify member eligibility and coverage.
- Electronic: submit a HIPAA 270 transaction (eligibility) to Anthem Blue Cross or through Availity

Where and how to submit BlueCard claims

You should always submit claims to Anthem Blue Cross. Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes a three-character prefix. Do not make up prefixes. Claims with incorrect or missing prefixes and/or member identification numbers cannot be processed.

Overlapping service areas

Submission of claims in overlapping service areas is dependent on what plan(s) the provider contracts with in that state, the type of contract the provider has (ex. PPO, Traditional) and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member’s claim with either Plan.
- If you have a PPO contract with one Blue Plan, but a Traditional contract with another Blue Plan, file the out-of-area Blue Plan member’s claim by product type.
- For example, if it’s a PPO member, file the claim with the Plan that has your PPO contract
- If you contract with one Plan but not the other, file all out-of-area claims with your contracted Plan.
- Very important - Use the Anthem Blue Cross Payer ID number that was assigned to you, not the Blue Shield of California Payer ID number. If you submit an Anthem Blue Cross member claim with the Blue Shield of California Payer ID number instead of the Anthem Blue Cross Payer ID number, the claim will process as out of network.
**Medicare Advantage**

Participation in the Medicare Advantage PPO Program is included under your Anthem Blue Cross Participating Mental Health Practitioner Agreement.

Email Behavioral Health Network Relations at CABHNetworkRelations@anthem.com for questions about your status in the Medicare Advantage PPO Network.

**Medi-Cal Managed Care**

This newsletter is intended to share information with our contracted commercial Behavioral Health providers. Medi-Cal Behavioral Health is serviced by a different operational team.

For questions about your status in the Medi-Cal Behavioral Health Network, email the Medi-Cal Behavioral Health Network Relations at BHMedi-CalNetworkRelations@anthem.com.

**Guidelines and Policy updates**

**Timely access regulations and language assistance program**

Blue Cross of California dba Anthem Blue Cross and Anthem Blue Cross Life & Health Insurance Company (collectively, “Anthem”) are committed to keeping you, our network partners, updated on our activities related to our compliance with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) Timely Access to Non-Emergency Health Care Services Regulations (the “Timely Access Regulations”), respectively. Anthem maintains 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 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 attain the information that is needed. These studies allow our Plan to determine compliance with the regulations.

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

- Provider Appointment Availability Survey
- Provider Satisfaction Survey
- Provider After – Hours Survey
These surveys will begin soon, please review this information with 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.

We hope this clarifies Anthem’s expectations and your obligations regarding compliance with the Timely Access Regulations. Our goal is to work with our providers to successfully meet the expectations for the requirements with the least amount of difficulty and member abrasion.
Anthem Blue Cross will soon contract with Psychiatric Mental Health Nurse Practitioners who offer Evaluation and Management services (formerly medication management). We are on track to complete activities by the end of the year. Supervising Psychiatrists that have an interest in their Psychiatric Mental Health Nurse Practitioners participating with Anthem Blue Cross, may send a letter of interest to us at fax number 858-278-7449. When we finalize all the details, we will contact interested providers and walk them through our contracting process.

### Access standards for Behavioral Health and EAP providers

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
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<tbody>
<tr>
<td>Emergency Care Instructions</td>
<td>Members are directed to 911 or the nearest emergency room.</td>
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<tr>
<td>Non-Life Threatening Emergency Care</td>
<td>Appointment within 6 hours</td>
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<tr>
<td>Urgent Care (does not require prior authorization)</td>
<td>Appointment within 48 hours</td>
</tr>
<tr>
<td>Urgent Care (requires prior authorization)</td>
<td>96 hours</td>
</tr>
<tr>
<td>Routine Office Visit/Non-urgent Appointment</td>
<td>10 Business days (Psychiatrists)*</td>
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<tr>
<td></td>
<td>10 Business days (Non-Physician Mental Health Care Providers)</td>
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<td></td>
<td>5 Business days (EAP)</td>
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<tr>
<td>Access to After-hours Care</td>
<td>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.</td>
</tr>
<tr>
<td>In Office Waiting Room Time</td>
<td>Usually members do not have to wait longer than 15 minutes after their scheduled appointment to see a Behavioral Health/EAP provider.</td>
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*The DMHC Timely Access Standard is 15 Business days for Psychiatrists however, to comply with the NCQA accreditation standard of 10 Business Days, Anthem uses the more stringent standard.*

Email questions to Behavioral Health Network Relations at CABHNetworkRelations@anthem.com.
Members also have access to Anthem's 24/7 NurseLine. The NurseLine wait time is not to exceed 30 minutes. The phone number is located on the back of the member ID card. In addition, members and providers have access to Anthem’s Customer Service team at the toll-free telephone number listed on the back of the member ID card. A representative may be reached within 10 minutes during normal business hours.

**For Patients (Members) with Department of Managed Health Care Regulated Health plans:**

If you or your patients are unable to obtain a timely referral to an appropriate provider or for additional information about the regulations, visit the Department of Managed Health Care’s website at [www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessToCare.aspx](http://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessToCare.aspx) or call toll-free **1-888-466-2219** for assistance.

**For Patients (Members) with California Department of Insurance Regulated Health plans:**

If you or your patients are unable to obtain a timely referral to an appropriate provider or for additional information about the regulations, visit the Department of Insurance’s website at [www.insurance.ca.gov](http://www.insurance.ca.gov) or call toll-free **1-800-927-4357** for assistance.

**Language Assistance Program**

For members whose primary language isn’t English, Anthem offers free language assistance services through interpreters and other written languages. If you or the member is interested in these services, please call the Anthem Member Services number on the member’s ID card for help (TTY/TDD: 711).

**Contract compliance with Accessibility Standards for Emergency Care instructions and After Hours Care**

As you know, Anthem monitors member access to Behavioral Health care through a number of mechanisms, including provider and member surveys. These surveys are conducted by North American Testing Organization (NATO), Anthem Behavioral Health Survey 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 2018 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 support and commitment in helping us achieve the best results possible for our 2018 surveys, which are currently being conducted.

In an effort to improve our results for 2018, Anthem Blue Cross is sharing the 2017 results below.

### Provider After Hours Survey 2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Result</th>
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<tbody>
<tr>
<td>Threshold &gt;85% of providers comply with the standard</td>
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<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>
<td>Medical: 86.8%</td>
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<td></td>
<td>Behavioral Health: 73.2%</td>
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<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>
<td>Medical: 81.1%</td>
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<tr>
<td></td>
<td>Behavioral Health: 71%</td>
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### How Can You Make a Difference?

- Review Anthem Blue Cross Access Standards under the Quality Improvement Program section 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 your office was surveyed in 2017 and found non-compliant with these After Hours requirements, you will have received a letter with recommended compliance measures.
We value your participation in the Anthem Blue Cross commercial Behavioral Health Network and appreciate your efforts to meet compliance with established access standards. For questions, email our commercial Behavioral Health Provider Relations team at CABHNetworkRelations@anthem.com.

**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 online on anthem.com/ca under Providers > Providers Overview. In the middle of the page select the dark orange box, Finding Resources for California. A new window opens, select the tab Health & Wellness > Practice Guidelines.

**Release of medical records**

Under federal law, members have the right to their records or to have them forwarded to an authorized person(s) on their behalf. A written request must be received before any information can be shared. Member privacy is very important to us and we must make every reasonable effort to keep it safe. Please adhere to terms of your Agreement and processes outlined in the Manual to maintain confidentiality of protected health information and records, comply with Anthem's Privacy Notice, and associated Health Insurance Portability and Accountability (HIPAA) standards.