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Announcements and General Updates

Pharmacogenetic testing for behavioral health conditions

Robert Friedman, MD, Medical Director, Behavioral Health Services – West Region

As therapists and psychiatrists know all too well, patients who take medications for psychiatric conditions often experience intolerable side effects. Others experience the lack of an adequate response to a particular medication. As a result, understandably, some patients stop taking medications altogether, resulting in the persistence or worsening of symptoms. Others experience the frustration of undergoing numerous sequential trials of multiple medications or dosage adjustments, leaving patients and their families as well as therapists and psychiatrists demoralized, as they struggle to find the optimal medication and dosage needed to treat the person’s condition. Patients sometimes become desperate to find an answer that will work for them. Therapists and doctors feel inclined to do all that they can in order to help their patients feel relief from suffering and restore them to optimal functioning.

As clinicians and patients search for solutions, the idea to request or order Pharmacogenetic testing sometimes surfaces. Doctors, therapists and patients have heard about the simple, although very expensive procedure that consists of taking a sample of blood or saliva, and having that sample sent to a special laboratory for analysis. There is an expectation that the results will inform us as to which psychotropic medications amongst the myriad of available antidepressants, antianxiety medications, antipsychotics, mood stabilizers and ADHD medications, will have the best clinical results for our patients. It is not unusual for the cost for this service to be billed at a rate of between three and five thousand dollars.

Unfortunately, despite anecdotal reports, patient testimonials and marketing efforts, the evidence to support the usefulness of pharmacogenetics testing in order to guide clinicians and patients toward the use of particular psychiatric medications on an individual basis in most circumstances, is lacking. While there is hope that in the future this type of testing will evolve to be more accurate and applicable, today, the science does not support its widespread use.

The principles of pharmacogenetics testing are sound. There are certain genetic variants amongst individuals that will play a role in how fast and effectively a psychiatric drug will reach the brain and the rest of the body, where the drug will exert its positive (treatment) effects and negative (side) effects, as well as how quickly the drug leaves the body, in other words, the drug’s “pharmacokinetics”. Other genes affect how the drug acts once it reaches the target site, or receptors. In the brain, this has to do with understanding how the drug regulates neurotransmitters such as serotonin and dopamine, in
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.

In other words, the drug’s “pharmacodynamics”. Terms such as the “Cytochrome P-450 system”, “genetic polymorphisms” and “fast vs. slow metabolizer” are relevant to understanding the science and study of pharmacokinetics and pharmacodynamics.

Applying these principles to clinical practice, however, is another story. With the exception of the use of the drug carbamazepine in individuals of Asian descent, the data needed to understand how such testing can help our individual psychiatric patients in our clinical practices today, is lacking. Evidenced based studies have not been able to establish the efficacy and usefulness of pharmacogenetics testing for psychiatric medications. Study outcomes have not demonstrated that pharmacogenetics testing for psychiatric medications is more helpful than applying the established treatment strategies of sound clinical practice.

To learn more, the following references may be of interest:


Improving consumer experience through ID cards

There are a limited number of unused three-character, alpha-only prefixes for member identification (ID) cards remaining, and they are expected to be exhausted in the 2nd or 3rd quarter of 2018. When that happens, we’ll begin assigning prefixes that contain a combination of letters and numbers, or alpha-numeric prefixes. At the same time, we’re redesigning member ID cards. Color highlights enhance important card information. The update makes the card stand out from other carriers making it easier to locate when needed.

What does prefix changes mean to you?

- It will be even more important to ask your patients for their most recent identification (ID) card.
- When submitting claims, enter the identification number exactly as it appears on the member’s ID card.
- Check your EDI Software now to make sure it can accept alpha-numeric prefixes.
- Check any internal documents you may have and update any references of “alpha prefix” to “prefix”.
- Note: current three-character, alpha-only prefixes will not be affected by this change. Current prefixes will still be valid once the new alpha-numeric prefixes are issued, unless there is another need to change or remove a prefix currently in use.

Redesigned ID card details

We’ll send you reminders of this upcoming change in future newsletters.
Electronic member ID cards

Anthem Blue Cross (Anthem) has a mobile app called “Anthem Blue Cross Anywhere” that allows members to manage their benefits on their smart phones, including electronic copies of their ID cards. The Anthem Blue Cross Anywhere mobile app allows members easy access to their ID card even when there is no internet connection.

Currently, members still receive hard copies of their ID cards, even if they utilize an electronic version. Starting in fall 2017, we will allow members the option to choose electronic cards only. If the member chooses this option, he/she will not receive a hard copy card. Members will continue to have the option of selecting a hard copy card if that is their preference.

We want to ensure a member’s request for electronic ID card meets a provider’s office needs. If presented with an electronic card, you may still obtain a copy of the ID card for your records.

Members that choose to use their mobile app will have the option to email or fax their ID Card from their smartphone, and providers can view (and print the card if needed) from the Availity Portal – NEW coming by January 1, 2018! Members are still required to have a copy of their card in one format or another, whether hard copy or electronic, in order for services to be rendered.

Anthem members that will have this option

- Individual commercial members will have this option starting in fall 2017 for plans becoming effective on or after January 1, 2018. (This includes all plans on and off exchange.)
- Most Small Group members will have this option upon their group renewals starting in fall 2017
- Most Medicare/Medicaid members will have this option in 2018
- Some Federal Employee Program® (FEP®) members will have this option in 2018
- Most Large Group members will have this option starting in 2019
- Most National Account members will have this option tentatively scheduled for 2020

A Quick Reference Guide will be available online in October 2017. The Electronic Member ID Cards – Quick Reference Guide will include details and information on options for obtaining a copy of an electronic Member ID card, even sample electronic Member ID cards.
Let us “guide” you

We’ve developed interactive guides providing our individually contracted providers and groups with answers to everyday behavioral health questions. Feedback has been very positive from the Professional Network providers and we’re pleased to announce an addition to our guide library supporting self-service for our participating Facilities. In August, we rolled out the “Behavioral Health Guide for Facilities”.

These guides cover a variety of topics, including understanding your Agreement, how to submit changes, our credentialing/recredentialing process and a glossary of common Anthem terms. You’ll find the FAQ section answers questions about the plans that are covered under your Anthem Agreement, how to resolve a claim issue and more - download, view, save or print!

Access all guides easily online. Go to anthem.com/ca > Providers > Learn More > Behavioral Health Provider Resources > Resources and Tools > Behavioral Health Guides, then choose the guide you need (Individual, Groups or Facilities).

If you have questions on any of the guides, feel free to contact Behavioral Health Network Relations by email: BHNetworkRelations@anthem.com.

Save time and money. Use the Availity Portal

Are you using the Availity Portal to help reduce costs and improve your organization’s efficiency? Whether you maintain an individual provider office or a group practice, you can quickly and easily perform many administrative tasks via the Availity Portal, including:

- Get current patient insurance coverage information (including eligibility and benefits)
- Monitor the status of your claims submissions*
- Submit single claims online
- Access remittance advices
- View your proprietary reports

If your organization is not registered, you can start the process right away. It’s easy; just go to Availity.com and select the Register button.

For questions or additional registration assistance, contact Availity Client Services, Monday to Friday, 5 a.m. to 3 p.m. PT toll-free at 1-800-Availity (1-800-282-4548).

*Note: the EDI Helpdesk call center cannot offer claim status detail.
ProviderAccess® will retire December 2017

The ProviderAccess secure website, or portal is scheduled to retire December 8, 2017. At that time, the Availity Portal (availity.com) will be your exclusive web portal for access to all Anthem electronic tools and resources.

As a reminder, here is some of the functionality available to you on the Availity Portal (Availity):

- Eligibility and Benefits
- Claims Status Inquiry
- Secure Messaging
- Remittance Advices
- Claims Submission
- Fee Schedule
- Professional Reimbursement Policies (currently scheduled for mid-September)
- Education and Reference Center (currently scheduled for mid-September)
- Clear Claim Connection

Availity Training:

If you would like more information on navigating in Availity, once logged in from availity.com, select Help & Training | My Learning Plan from the top navigation menu on the Availity home page to plot your learning journey. Availity also offers onboarding modules for new administrators and users. You may also access these training modules by selecting Help & Training | Get Trained and type “onboarding” in the search field.

For more information on Anthem features and navigation, select Payer Spaces | Applications | Education and Reference Center (coming mid-September) to find presentations and reference guides that can be used to educate provider staff on Anthem proprietary tools.

We encourage you to start using the Availity Portal today.

Check out payer spaces: find more of what you need

Anthem is continuing to enhance our Payer Spaces offerings found on the Availity Portal. You can access remittances and fee schedule information, which are important and valuable tools. If you should have access to any of these great features but you don’t currently see them, contact your organization’s Availity administrator to request access.
When you are navigating in Payer Spaces, make sure to check out both the Applications and the Resources tabs to view all the options that are available to you.

Next up, Anthem will be introducing the Education and Reference Center under Payer Spaces on the Availity Portal. The Education and Reference Center will contain all of the important documentation currently on ProviderAccess®. This will allow you to seamlessly navigate quickly to forms and information without having to jump to another portal (secure website) to access it. The Education and Reference Center is currently targeted for October 2017.

Confidential voicemail

If your voicemail or answering machine is confidential, let us know in your outgoing message. Due to HIPAA requirements, we will leave detailed voicemail or answering machine messages only when the outgoing message indicates confidentiality is maintained.

Health Care Reform Updates (including Health Insurance Exchange)

Important information available online

You’re invited to visit our provider website to learn about the many ways health care reform and health insurance exchange may impact you. Information is added regularly and you’ll find the latest articles on health care reform and health insurance exchange, along with all archived articles.

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

Changes to individual health plan offerings for 2018

For more than seven decades, we’ve been proud to offer affordable health plans that give Californians access to quality health care. In 2013, when the Affordable Care Act (ACA) started, we created a new set of quality, affordable health plans to offer consumers through the Health Insurance Marketplace, also called Covered California. But the market for these plans has become unstable. And with federal rules and guidance changing, it's no longer possible for us to offer some of those plans.
As a result, starting **January 1, 2018**, we will offer plans in three key Covered California rating regions which cover 28 counties. The coverage will include an Exclusive Provider Organization (EPO) plan and will be available both on-exchange and off-exchange, and at all metal levels. Please note, **this does not impact people with Anthem’s employer-based insurance, Medicare Advantage, Medicare Supplement, Medi-Cal, or individuals and families whose plans are “grandfathered”** (grandfathered plans must have been purchased prior to March 23, 2010).

Member notifications will begin September 2017 communicating health plan coverage options available as of January 1, 2018. **There is no benefit impact at this time.** Member benefits can be used without interruption until the end of 2017.

As the individual marketplace continues to evolve, we will reevaluate the need for future changes always focused on offering timely access to affordable, quality health care to our members.

**Additional resources:**
- Covered California - [www.coveredca.com/](http://www.coveredca.com/)
- California Department of Managed Health Care - [www.dmhc.ca.gov/](http://www.dmhc.ca.gov/)

**Billing**

**Overpayments**

When an overpayment is identified Anthem Blue Cross (Anthem) requires supporting documentation along with the refund.

Attaching only the EOB or listing just the claim number with no explanation other than “Overpayment” may prevent the processing of your refund. Accordingly, it’s important that you provide the following information:

- Claim number
- Patient name
- Concise explanation for the refund
- Billing codes

Anthem will accept this information electronically or by mail. By providing this critical information, can expedite the process, more efficiently and timely.
Overpayment contact information:

<table>
<thead>
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<th>Service Area</th>
<th>Telephone</th>
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<td>Large Group</td>
<td>818-234-3289</td>
</tr>
<tr>
<td>Individual Plans</td>
<td>818-234-3289</td>
</tr>
<tr>
<td>Small Group</td>
<td>818-234-3289</td>
</tr>
<tr>
<td>BlueCard®</td>
<td>800-444-2726 toll free</td>
</tr>
<tr>
<td>Medicare Advantage HMO/PPO</td>
<td>818-234-3289</td>
</tr>
<tr>
<td>FEP</td>
<td>800-824-8839 toll free</td>
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**Update to provider remittances**

Beginning August 2017, Anthem will update information on some paper provider remittances to make it easier for providers to identify and track refunds and recoupments. Updated remittances will include a new section titled “Negative Balance Deferred” under the Recoupment Notification portion of the remit. This change will make it easier for providers to identify overpayments that have not yet been released for recoupment. A column titled “Expected Recoup Date” will indicate the date the overpayment will be released for recoupment. If the date reflected in the column is 12/31/9999, this indicates that the provider should return a check for the specified amount, or confirm that Anthem can recoup the monies by signing and returning the recovery letter that is sent separately.

Additionally, the check number associated with a refund will be added to the remittance. For voluntary refunds, the check number will be reflected to the immediate right of the word “Refund” in the upper portion of the remittance. For refunds for an overpayment, the check number will be reflected in the “Claim Number/Refund ID” column under the following sections: Negative Balance History, Prior Recoupment and Current Recoupment. This information will allow providers to more easily determine the check number applied to the outstanding balance due.

If you have any questions, please call the number indicated at the bottom of the recovery letter.
Remittance inquiry search option streamlined. Check it out!

We’ve changed the Check/EFT search option to make it easier for you to find your remittances. Choose one of two search options:

- Search by Check/EFT which now only requires a Tax ID and does not require an NPI.
- Use a date range search which does require both, a Tax ID and NPI.

Here’s how to access your remittances from the Availity Portal:

From the Availity Portal home page, select Payer Spaces, next choose Anthem BlueCross from the list of payer options, and then select Remittance Inquiry.

Need a copy of the remittance for your records?

Select the View Remittance link associated with each remit to access the imaged copy of the paper remittance. You will then have the option to print or save.

Don’t see this valuable tool when you log in to the Availity Portal?

Contact your Availity Administrator to request Claims Status access which includes Remittance Inquiry. If you do not know who the administrator is for your organization, log in to Availity, go to your account and select, Who controls my access?

Try the Remittance Inquiry application today and see for yourself how easy it is to retrieve your remits!

No go for “no shows”

Anthem doesn’t reimburse for cancellations or “no shows.” However, we understand that some practices impose financial penalties on members who miss appointments. While this practice may not be expressly prohibited by your Agreement (contract) with Anthem, we ask that you exercise compassion and sufficiently consider the member and his or her medical condition before actually imposing a penalty. These penalties must not be a barrier to access. Members can be accountable for “no-shows” if and only if the member has signed an agreement prior to rendering services, indicating consent to personally accept financial liability prior to the “no-show”, and if cancellation is not in accordance with the office’s cancellation policy. Any penalty cannot exceed the applicable contract rate. You are responsible for advising the member of the office policy indicating responsibility for a cancellation or “no show” fee when the office policy is not followed.
Help with claim issue resolution

If you have an issue or question about a claim, call Claims Customer Service or send an online secure message through the Availity Portal (Availity). When calling Customer Service have this information: member ID number, claim number (DCN) and prior call reference number. The reference number, also known as a tracking number is a record of you contacting Anthem previously. If you have a need to call Anthem more than once, ask for the reference number each time. If the issue remains unresolved, ask for a supervisor.

If the issue isn’t resolved with a Customer Service representative or supervisor, submit a provider dispute including any reference number(s) supporting any previous calls about your issue.

Availity: secure messaging an option for claim questions

Secure messaging gives you the opportunity to “ask a question” about a claim online. Send a question to clarify the status or get additional information on a claim. Secure Messaging is a feature accessible thorough Availity.

These messages can be sent for local Anthem, Anthem Blue Cross Blue Shield, BlueCard® out-of-area, and FEP (Federal Employee Program) Member claims.

Note: If you receive a bar-coded mail-back letter regarding a claim, do not use Secure messaging to respond. Instead place the mail-back letter on top of the requested information and follow the mailing instructions.

Send a Secure Message

1. Under the heading, “Send a secure message” choose the link, “Do you have a question about this claim?”
   
   Note: This option will only appear if your organization’s Administrator has set up your account to include Secure Messaging.

2. Another window will open on your computer. Choose one of the seven questions from a drop-down box and use the free-form text box to add detailed information related to your question.

3. Select Submit. You will receive an Inquiry Control Number (ICN), which confirms your Secure Message has been sent and received.
How are Secure Messages processed?

- Your secure message is routed to Anthem Blue Cross Customer Service departments for a response through the secure messaging system, eliminating the need for you to make a phone call for the same information.
- If you have additional questions on a claim based on the response, you can reply to Customer Service’s response with further questions.
- Messages are stored within the Secure Messaging tool, accessed under the Claims menu option on the Availity Portal, in the inbox and outbox. You can review messages you previously sent, view new responses received, and save messages to your computer or print for your records.
- Secure Messages are housed within a self-contained, secure email system, separate from your office email account. The messages are sent and received using your login credentials for the Availity Portal.

Secure Messaging should be used when you need to:

- Inquire on the status of a claim
- Have a billing/claim reimbursement question
- Need to submit proof of timely filing
- Request for retraction related to Third Party Liability or Worker’s Compensation
- Ask why the claim was processed incorrectly; provide reasons
- For more information refer to the “Availity” section of your Manual.

Contracted provider dispute resolution

The Provider Dispute Resolution Request (PDR) form is used to initiate the formal dispute process for a claim that has already been adjudicated or when you, the provider disagrees with an Anthem billing determination.

Uses for the Provider Dispute Resolution Request (PDR) form:

- Dispute the resolution of an adjudicated claim
- Appeal a Medical Necessity or Utilization Management decision
- Respond to a notice of overpayment or to appeal Anthem overpayment withhold of an adjudicated claim
- Submit documentation for a contract dispute
- When there’s a denial of Medical Group responsibility
- For submissions of similar multiple claims, billing, or contractual disputes, which may be batched as a single dispute, utilizing the second page of the PDR form to detail the attachments
- For other submissions that occur after adjudication of the claim
Keep these things in mind:

- Fields with an asterisk (*) on the form indicate required information. Complete necessary information accurately - provider name and Tax ID, member name and ID.
- Contracted provider disputes must be received by Anthem **no later than 365 days** from Anthem’s action that led to the dispute (or the most recent action, if there are multiple actions that led to the dispute).
- Contracted provider disputes that don’t include required information may be returned. An amended provider dispute, which includes the missing information, may be submitted to Anthem Blue Cross within **30 working days** of receipt of the returned dispute.
- A dispute letter is acceptable in lieu of the form; however, it will go to the respective department as correspondence first and then be forwarded to the Grievance & Appeals unit. If a claim accompanies the PDR form or letter, all information will first be sent for processing of the claim.
- For an electronically submitted claim dispute, print and attach a hard copy of the claim to the PDR form.
- Once Anthem receives the dispute, the Grievance & Appeals department will send an acknowledgement letter within five calendar days of the date of receipt.
- Disputes related to Stop Loss are to be submitted to:
  
  Anthem Blue Cross  
  Attn: Stop Loss AC09F  
  21555 Oxnard Street, Woodland Hills, CA 91367

- Disputes which result in past due payments will be paid within five working days of issuance of the written determination, including interest and penalties required by law or regulation.
- After completing the form, place it on top of all documentation and mail to:
  
  Anthem Blue Cross  
  P.O. Box 60007  
  Los Angeles, CA 90060-0007

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

File claims electronically – it’s fast, easy and the preferred method of claims submission.

**Why submit claims electronically?**

- HIPAA compliant – secure computer-to-computer transfer of information
- Save up to $10 per claim by reducing paperwork, manual intervention, postage and form stock
- Electronic claims are faster and more accurate; transmit 24/7 avoiding postal delays
- Notification and error reports provide receipt of your electronic claim
- Electronic remittance advice is offered to electronic submitters and allows posting payments automatically
Ways to prevent delays

- Use the Anthem Blue Cross Payer ID code: 47198
- If you submit through a clearinghouse or use a software vendor, check with them for the correct value (code) for Anthem Blue Cross claims
- Correct rendering provider information, including individual provider NPI and Tax ID is on the claim(s) before submitting
- Correct member information (Anthem Member ID, name, date of birth) included on the claim(s)
- Submit original claims within 12 months of performed services

Network

Can interns, physician or psychological assistants render services?

No. Participating Behavioral Health providers are required to personally render covered services to Anthem members. Services rendered by interns and assistants aren’t covered, even if supervised by the licensed provider.

**Note:** The only licensed provider types eligible to participate in the Anthem Blue Cross Behavioral Health Network and submit for reimbursement include: psychiatrists, psychologists, neuropsychologists, clinical social workers, marriage-family therapists, clinical professional counselors, psychiatric mental health nurses, or psychiatric mental health nurse practitioners. Solely for the provision of Behavioral Health therapy, an unlicensed board certified behavior analyst. All providers must successfully complete credentialing.

Mental Health Practitioner Agreement covers many plans

Under your Commercial Anthem Blue Cross Participating Mental Health Practitioner Agreement (Agreement), you are contracted for any Anthem Blue Cross (Anthem) plans that access the Anthem Behavioral Health Network. This includes but is not limited to Commercial HMO, PPO, EPO plans, and plans on and off the exchange (Pathway HMO, PPO, and EPO) and Medicare Advantage PPO Plans. This does not include the Medi-Cal Managed Care Program (Medi-Cal) or EAP. Refer to the article, “Network Relations teams aren’t the same – where to go with questions” in this newsletter for contact information on specific Network Relations teams.
Network Relations teams aren’t the same – where to go with questions

Behavioral Health providers can be contracted under three 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 - BHNetworkRelations@anthem.com
- Medi-Cal Behavioral Health - BHMedi-CalNetworkRelations@anthem.com
- EAP - EAPProviderNetworks@anthem.com
- Commercial Medical – CACContractSupport@anthem.com (Non-Behavioral Health physicians)

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 to the Anthem Blue Cross website: anthem.com/ca. Scroll down to the “Providers | Spotlight” section and select the link, Provider Education Seminars and Webinars.

Web support offers login and technical assistance

We recognize that technology can sometimes be challenging and we’re here to help.

- Availity: Call toll-free 1-800-AVAILITY (282-4548)
- ProviderAccess®: Call toll-free 1-866-755-2680 or email provideraccess.pins@anthem.com.

Workers’ Compensation provider termination list

As a reminder, Anthem Workers’ Compensation (AWC) publishes our listing of the “Other Payors” leasing our network in the Network Leasing Arrangement available in, the secure websites, Provider Access® and Availity. The list is updated on a monthly basis to include:

- New and Terminated “Other Payors”
- New and Terminated Medical Provider Networks (MPN)

Please be sure to check for updates monthly. If you have any questions regarding the status of any
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.

“Other Payor” or MPN please contact AWC Customer Relations at 1-866-700-2168 toll free or email us at AWCCustomerRelations@anthem.com.

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 cannot go online, call Anthem Workers’ Compensation toll-free at 1-866-700-2168 and we can take action on your behalf in the Provider Affirmation Portal. Keep an eye out for email notifications from “Anthem MPN Admin.”

Note: the Provider Affirmation Portal will also notify participating medical providers when an MPN is terminating its relationship with Anthem and/or the Division of Workers Compensation.

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 will be conducting semi-annual outreaches to all practices 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. We appreciate your attention to this matter. Send questions about updating your practice to BHNetworkRelations@anthem.com.

Anthem Blue Cross’ “Find a Doctor” tool

Our “Find a Doctor” tool is used by consumers, members, brokers, and providers to identify in-network (contracted or participating) physicians and other health care providers supporting member health plans. Ensure Anthem Blue Cross (Anthem) has the most current and accurate information about your practice. Take a moment to access the “Find a Doctor” tool at anthem.com/ca. Review how you and your practice are being displayed and that the information is accurate.
Follow steps 1-4 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.
3. E-mail the form to: ProviderDatabaseAnthem@anthem.com.
4. E-mail “Subject Line” should read: **BH CHANGE.**

Example:

<table>
<thead>
<tr>
<th>To...</th>
<th><a href="mailto:ProviderDatabaseAnthem@anthem.com">ProviderDatabaseAnthem@anthem.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>BH CHANGE</td>
</tr>
</tbody>
</table>

Detailed information about submitting practice changes can be found in our Behavioral Health Guides for Contracted Providers.

**Forms make practice changes easy**

Practice information helps us direct referrals and members who access care directly. It’s an important component in delivering timely access to care. Since the passage of Senate Bill 137, we are more committed to ensuring accurate information in our provider directories. You play a big role in keeping our provider directories up-to-date.

Is your practice information (e.g. practice address, areas of expertise, etc.) accurate? Prevent member servicing delays and notify us of any practice changes promptly. 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:

- E-mail address
- Check/EOB/Billing/Reimbursement address
- Mailing/Correspondence address
- Practice/Service address
- Phone and fax number
- Open/closed practice status
- TaxID (include a **W-9 form** with your change)
- NPI
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Use the Practice Profile when updating:

- Self-reported areas of expertise
- Psychiatrists update ECT, TMS, Suboxone, and anti-psychotic injectable management if applicable.
- Open/closed practice status
- Age ranges treated
- Additional languages spoken
- Provider ethnicity (optional)

**Practice status - open or closed**

Prompt written notice of a closed practice prevents member servicing delays. Refer to the Quality Improvement section of the Anthem Blue Cross Professional Manual (Manual), subsection Open or Closed Practice for timeframes and information about reporting your practice status.

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.

Submit an update using one of the forms mentioned in “**Forms make practice changes easy**”, an article in this newsletter or by written notice. Don’t forget to tell us how long your practice is closed for.

**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 > Providers > scroll to Panel Consideration and follow the instructions to request an application. 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.](#)

**Psychiatric Mental Health Nurse Practitioners are in demand**

Are you a supervising psychiatrist interested in having your Psychiatric Mental Health Nurse Practitioner participate in the Anthem Blue Cross Behavioral Health Network? Find out how at anthem.com/ca > Providers > Learn More > Behavioral Health Provider Resources > [Join Our Networks](#)

**Anthem Blue Cross cost transparency**

As an Anthem Blue Cross (Anthem) participating Behavioral Health provider, you may have received our prior correspondence, or read the articles in our 2016 Network Updates on Anthem Cost Transparency, specifically Anthem’s Estimate Your Costs tool available to members on our [anthem.com/ca](http://anthem.com/ca) website.
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.

In our prior correspondence, we also enclosed summary of the methodology used to generate the cost information housed in BCBS Axis (formerly the National Consumer Cost Tool or NCCT), the source data used to display costs in Estimate Your Costs. The treatment categories for which costs are displayed and the methodology are defined by the Blue Cross Blue Shield Association. As indicated in the correspondence, BCBS Axis cost data is updated twice annually; the most recent update completed in May 2017, and the next update scheduled for November 2017. Please look for more information in our upcoming provider newsletters posted to anthem.com/ca.

As a reminder, participating Anthem provider costs are now available in a secure section of the Availity Portal. Authorized representatives of participating facilities and professional practices can login to Availity at availity.com, and register to view the costs for their facility or practice. 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 via the Estimate Your Costs function.

If you wish to review the methodology or request a copy, please e-mail the Anthem California contract support team at CAContractSupport@anthem.com.

**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
- 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 e-mail addresses as you like.
Network leasing arrangements

Anthem 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 members. As such, they’re entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. View the Other Payors list on ProviderAccess®, which can be accessed through the Anthem website at anthem.com/ca. If you have questions or don’t have Internet access, e-mail Behavioral Health Network Relations at BHNetworkRelations@anthem.com.

Guidelines and Quality Programs

Re-attest to your CAQH ProView profile today

Anthem uses the CAQH ProView® system to gather and coordinate the information needed for credentialing. If you are due for an upcoming re-credentialing event and have not accessed CAQH ProView recently, please take a moment to login to CAQH ProView, update your data profile and re-attest to your information.

Re-attestation is due every 120 days, and it is very important to keep your data profile accurate and current so that Anthem can complete the credentialing process without requiring additional outreach to you. Below are frequently asked questions regarding the CAQH ProView system.

What is CAQH ProView?

CAQH ProView is an online provider data-collection solution. It streamlines provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital and other healthcare organization.

CAQH ProView enables physicians and other healthcare professionals in all 50 states and the District of Columbia to enter information at no charge into a secure central database and authorize healthcare organizations to access that information. CAQH ProView eliminates redundant paperwork and reduces administrative burden.

Does it cost anything to use CAQH ProView?

There is no cost for physicians and other health care providers to use CAQH ProView.
How do providers access CAQH ProView?

Providers can register online at https://proview.caqh.org/, or will receive registration instructions once Anthem notifies CAQH that the provider needs to access the database. Once registered, use the CAQH Provider ID and password to access CAQH ProView.

How do providers complete the CAQH ProView data collection process?

Completing the online form requires five steps:

1. Register with CAQH ProView.
2. Complete the online application and review the data.
3. Authorize access to the information.
4. Verify the data and attest to it.
5. Upload and submit supporting documents.

Why should providers respond to CAQH re-attestation notices?

After providers complete their CAQH ProView applications, CAQH will notify them every four months to re-attest that all information is still correct and complete. This enables a provider’s contracted participating organizations to access CAQH ProView profile information based on their different re-credentialing cycles.

Who can I contact for help or if I have any questions about CAQH ProView?

Contact the CAQH Provider Help Desk:

- Toll-free Phone: 1-888-599-1771
- Email: providerhelp@proview.caqh.org
- Help Desk Hours: Monday – Thursday: 4 a.m. to 6 p.m. PT and Friday: 4 a.m. to 4 p.m. PT

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,
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.

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.
### Access standards for Behavioral Health and EAP providers

<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>Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller is 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 the emergency room if the caller is experiencing an emergency. Members are directed to 911 or the nearest emergency room.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Life Threatening Emergency Care</strong></td>
<td>Appointment within 6 hours</td>
</tr>
<tr>
<td>Members are directed to 911 or the nearest emergency room.</td>
<td>Members are directed to 911 or the nearest emergency room.</td>
</tr>
<tr>
<td><strong>Urgent Care (does not require prior authorization)</strong></td>
<td>Appointment within 48 hours</td>
</tr>
<tr>
<td>Members are directed to 911 or the nearest emergency room.</td>
<td>Members are directed to 911 or the nearest emergency room.</td>
</tr>
<tr>
<td><strong>Urgent Care (requires prior authorization)</strong></td>
<td>96 hours</td>
</tr>
<tr>
<td><strong>Routine Office Visit/Non-urgent Appointment</strong></td>
<td>15 Business days (Psychiatrists)**</td>
</tr>
<tr>
<td>10 Business days (Non-Physician Mental Health Care Providers)</td>
<td>5 Business days (EAP)</td>
</tr>
<tr>
<td><strong>Access to After-hours Care</strong></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><strong>In Office Waiting Room Time</strong></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>
</tr>
</tbody>
</table>
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** This date is 10 Business days for Psychiatrists when the appointment is an initial appointment due to accreditation standards.

E-mail any questions to Behavioral Health Network Relations at BHNetworkRelations@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 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: [http://dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessstoCare.aspx](http://dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessstoCare.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 [insurance.ca.gov](http://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).

**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 at [anthem.com/ca > Providers > Enter > Health & Wellness > Practice Guidelines](http://anthem.com/ca/Providers/Enter/HealthWellness/PracticeGuidelines).
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Misrouted protected health information (PHI)

Providers and facilities are required to review all member information received from Anthem Blue Cross (Anthem) 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 e-mail. 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.

BlueCard®

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. Go online to anthem.com/ca > Providers > Enter > Health & Wellness > Quality Improvement and Standards > Member Rights & Responsibilities.

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.

Verifying BlueCard member eligibility and coverage

- For Anthem Blue Cross members, visit our website anthem.com/ca
- Other Blue Plans: contact Anthem Blue Cross electronically or through Availity at availity.com or 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.

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 BHNetworkRelations@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 information is available online at https://mediproviders.anthem.com/ca

E-mail Medi-Cal Behavioral Health Network Relations at BHMedi-CalNetworkRelations@anthem.com for questions about your status in the Medi-Cal Behavioral Health Network.

Pharmacy

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 quarterly.

Website links for the Federal Employee Program® (FEP®) formulary are:

- Basic Option
- Standard Option

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies