# Network Update

**COMMERCIAL BEHAVIORAL HEALTH**

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Announcements and General Updates

Note from our Medical Director

Hello Anthem Blue Cross providers! We are half way through another year and I would like to invite you to re-visit Anthem’s Behavioral Health Provider Resources website. There, you will find useful information and resources to help with your day-to-day practice.

Anthem’s Behavioral Health Provider Resource website can be found by going to anthem.com/ca. At the top the navigational menu select, Providers | Providers Overview. Scroll the page to the section Featured Resources, then select the link, Behavioral Health Provider Resources.

You can also get there directly by entering anthem.com/ca/behavioralhealth in your computer web browser address bar. It may be a good idea to add it to your “favorites”.

There are five headings or tabs at the top of the page, each of which contain links to information relevant and useful to your practice. Access Behavioral Health newsletters, forms, guidelines, toolkits and other resources by selecting a tab. There is so much information for you discover!

Please take a moment to explore these sites and links, and stay tuned for ongoing updates.

Robert Friedman, MD
Behavioral Health Medical Director

New email for contracted behavioral health 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 (group add) to an existing Anthem Blue Cross Participating Behavioral Health Group Agreement (contract) to mailbox: CABHGroups@anthem.com. Make sure your email subject line includes the following three things: the words “Add to group”, your group name and the primary county served.

Again, this new 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 the following three things in the subject line: the words “Add to group status”, your group name and the primary county served.

Immediately 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. Send Behavioral Health Network Relations questions to this team only. 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 those. 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. Beginning in March 2018, we continued with improvements to include an automatic state detection feature allowing you to quickly navigate to state-specific information.

**Refer to an in-network laboratory**

You should refer members to in-network laboratories to maximize their laboratory benefits and minimize their out-of-pocket expenses. If a circumstance arises where an out-of-network referral is necessary, call Utilization Management toll-free at 1-800-274-7767 to request prior authorization. Authorization must be received before referring members to any out-of-network provider.

For a complete listing of in-network laboratories, search our online provider directory, Find A Doctor accessible via anthem.com/ca. The article, Anthem’s online provider directory in this newsletter provides navigational instruction on how to complete an online search.
**Member responsibility for non-covered services**

As a contracted professional or facility provider, you agree not to bill members for non-covered services, unless you obtain a signed waiver from the member prior to rendering the services and after Anthem has denied the services. Refer to your signed Agreement, under the *Compensation and Billing* section, for specific contract language.

Have you heard of the Member (Patient) Responsibility Agreement - Waiver Form? The waiver is an agreement form approved by Anthem, through which the member accepts liability for non-covered services. You’ll find the form in the *Exhibits* section of the Manual.

For a waiver letter to be effective and valid, it must:

- Be obtained and executed in advance, just prior to the delivery or rendering of any service
- Specify those services which have been denied as not being medically necessary or non-covered
- Clearly state the member is responsible for payment of services denied as not medically necessary
- Be signed and dated by the member

**Anthem Blue Cross streamlines member identification cards**

Beginning July 1, 2018, we introduced a streamlined member identification (ID) card to help reduce confusion about member cost share. The updated member ID card maintains the current style, but specific cost share information (such as copays or coinsurance) will be removed from the card.

You can access Availity and the Electronic Data Interchange (EDI) to verify member benefits and obtain the most up-to-date cost share information for a member’s plan. If a member presents an older ID card with outdated benefits it can create confusion about member cost share.

As the streamlined ID card is adopted, it will help reduce misunderstandings around cost share. Additionally, members will be encouraged to learn more about their benefits through Anthem’s digital and online tools and can retain their card for as long as they remain in the same product plan, regardless of changes to cost share information. As a reminder, members can view, download, email, and fax an electronic version of their member ID card using the *Anthem BC Anywhere* mobile app. Electronic ID cards will also be updated as described above.

Please note, this update does not apply to National Accounts, Federal Employee Program® (FEP®), Medicaid or Medicare plans.

For questions, please contact the provider service number on the back of the member ID card.
Understand our credentialing program

Anthem’s Credentialing Program accesses information through the web solution, CAQH ProView™. Make sure your credentialing data is current, attested and that Anthem has been given viewing rights.

This is required for providers contracted in the Anthem Behavioral Health Network. Remember to attest every 120 days or as needed to avoid network participation interruptions due to outdated information (e.g., addresses, or liability coverage, etc.)

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the provider’s (practitioner) or Health Delivery Organization’s (HDO), licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards as well as those required by regulatory or accrediting bodies. **All applicable practitioners and HDOs in the network within the scope of the Anthem Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.**

HDO (facility) - The recredentialing process incorporates re-verification of changes not limited to a facility’s accreditation, certification or licensure (if applicable), sanctions, or malpractice experience that may reflect on the facility’s competence.

When requested by our Anthem Credentialing team, submit the following required facility documentation:

- Legible copy of a valid state license or certification (as applicable)
- Confirmation that your facility has been approved by a recognized accrediting body* (ex. copy of TJC accreditation certificate)

*In the absence of such accreditation, the most recent completed site survey report by Medicare or the appropriate state oversight agency must be provided, along with the statement of deficiencies, your plan of correction, the state licensing letter accepting your plan of correction and any revisit summary.

It is important that you respond to our request for an update of credentialing information whether you are a practitioner or facility, no later than 14 days after receipt of the request to prevent termination from our network.

Recredentialing questions: Email the Anthem Credentialing team at credentialing@anthem.com or call toll free at **1-800-516-7587** between 5:30 am – 2 pm PT to leave the department a message.
Behavioral Health related medical policies and clinical guidelines

In June, we mailed a summary of new and updated Medical Policies (MP) and Clinical UM Guidelines (CG). You can review the letter here. Access the online list of our MP and CG on our provider web site at anthem.com/ca > Providers | Providers Overview > scroll to Read Policies > Medical Policies and Clinical UM Guidelines (for Local Plan members), at the bottom of the page, select Continue.

If you have questions regarding the Anthem MP and CG, contact the Utilization Management Department toll-free at 1-800-274-7767.

Streamline work flow with solicited medical attachments

Has your office received a request for additional information to process a claim for a commercial Anthem Blue Cross (Anthem) member? Those records can be submitted electronically using the Medical Attachments feature available in the Availity Portal (Availity).

The Medical Attachments feature makes submitting electronic documentation in support of a claim simple and streamlined. Use your tax identification number (Tax ID) or NPI to register and submit Anthem requested medical record attachments through Availity.

Anthem’s solicited Medical Attachments feature supports an unlimited number of document attachments for each submission, and can handle .tiff, .jpg and .pdf attachments. If you receive a letter requesting additional documentation, you can send up to 10 attachments for each claim. The maximum file size is 10MB per attachment and file sizes larger than 10MB can be split into smaller ones.

How to access solicited medical attachments

Availity Administrator, complete these steps:

From My Account Dashboard, select Enrollments Center > Medical Attachments Setup, follow the prompts and complete the following sections:

1. Select Application > choose Medical Attachments Registration
2. Provider Management > Select Organization from the drop-down. Add NPIs and/or Tax IDs. Multiples can be added separated by spaces or semi-colons
3. Assign user access by checking the box in front of the user’s name. Users may be removed by unchecking their name.
Using Medical Attachments Availity User, complete these steps:

1. Log in to availity.com
2. Select **Claims & Payments > Medical Attachments > Send AttachmentTab**
3. Complete all required fields of the form
4. Attach supporting documentation
5. Submit

**Need Training?**

To access additional training for this Availity feature:

1. Log in to availity.com
2. At the top of any Availity web page, select **Help and Training > Get Trained**
   
   **Note:** Make sure you do not have a pop-up blocker turned on or the next page may not open.
3. In the new window a list of available topics will open. Key word search, **Medical Attachments**

Need More Information? Email questions to our Behavioral Health Network Relations team.

**Misrouted protected health information**

Providers and facilities are required to review all member information received from Anthem Blue Cross (Anthem) and other providers 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 inform the sender and to destroy any misrouted PHI and 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.
Health Care Reform Updates (including Health Insurance Exchange)

Important information available online

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 the 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.

Billing

Anthem engages with Alliant Health Solutions

Anthem has established a contractual relationship with Alliant Health Solutions to assist the organization in validating provider compliance with applicable reimbursement policies and identify instances of incorrect billing for behavioral health services. Alliant, is a behavioral health audit and review company, and will examine Anthem outpatient behavioral health claims data. Utilizing systematic sampling methodology and a broad range of algorithms, the audits and findings will be customized to support Anthem’s expectations as outlined in the Manual and related policies and procedures. Alliant findings may result in provider audits, record reviews, education and other outreach.

Availity is Anthem Blue Cross’ strategic partner

Anthem Blue Cross (Anthem) has recently moved into a strategic partnership with Availity to serve as our designated EDI gateway and E-solutions Service Desk.

- Availity and Anthem are working together to develop new ways to simplify how you manage claims and other administrative tasks online.
- Beginning June 1, 2018, you are able to manage all changes and new setup requests for the electronic remittance advice (835) through the Availity Portal.
- To register or manage account changes for electronic funds transfers (EFT) only, continue to use the EnrollHub at solutions.caqh.org
- If you directly submit your electronic transactions to Anthem and have your own practice management software, Availity provides trading partner services and access to tools via an easy setup experience.
- If you use a clearinghouse, they will work with Availity on your behalf.
Next steps if you are a direct submitter.

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<td>Go to <strong>availity.com</strong>, choose LOGIN, and log in to your account.</td>
<td>If you aren't registered for Availity go to <strong>availity.com</strong>, choose the REGISTER button. Refer to the <strong>Quick Guide</strong> if you need help.</td>
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<tr>
<td>Under <em>My Providers</em>, select <strong>Enrollments Center</strong>.</td>
<td>Select the registration process that is appropriate to your organizational type.</td>
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<td>Select, <strong>ERA Enrollment</strong> and then follow the online instructions to complete and submit your enrollment.</td>
<td>Availity will send you follow-up emails with your login credentials and guidance for your next steps.</td>
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<td>After submitting, you will be notified by email that enrollment is complete and start receiving 835’s through Availity. Please allow 5-10 business days for processing.</td>
<td>At this point you will be able to utilize all the Availity benefits such as <strong>Claim Status</strong>, <strong>Eligibility</strong> and now <strong>EDI</strong>.</td>
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Key factors:

- You are able to manage changes or new registrations for the electronic remittance advice (835) through your Availity Portal account beginning June 1st 2018. We encourage you to register with Availity to initiate the change to the Availity EDI Gateway.
- Anthem and Availity are committed to transparency with this change, and will emphasize the continuity of quality service to our trading partners.

We look forward to delivering a smooth transition to Availity for our EDI services. If you have any questions or concerns call the E-solutions Service Desk toll-free at **1-800-470-9630** or Availity at **1-800-AVAILITY** (1-800-282-4548).

**Reimbursement policies in a new location**

We are making it easier for you to find the information you need. The reimbursement policies, previously on ProviderAccess®, moved to the Availity Portal (Availity) at **availity.com**. Once logged in, go to Payer Spaces > Education and Reference Center > Administrative Support. Then search for the link **Reimbursement Policies and McKesson Claims Xten™ Rules** that will take you to a downloadable pdf of the policies.

Thank you for your attention to this update. If you have any questions, email commercial Behavioral Health Network Relations at [CABHNetworkRelations@anthem.com](mailto:CABHNetworkRelations@anthem.com).
**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 via 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 through Availity.

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

**Note:** If you receive a bar-coded mail-back letter about 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 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, 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 Availity.

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

Contracted provider dispute resolution

If you have an issue or question about a claim, your first step is to call Claims Customer Service or send an online secure message via Availity. If your claim issue isn’t resolved via a Customer Service representative, supervisor, or Availity secure messaging, submit a provider dispute including any reference number(s) supporting any previous calls about your issue.

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 Blue Cross (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 an 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 acknowledgment 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

Sign-up for electronic funds transfer

If you still receive reimbursement from Anthem by paper check, it’s time to go green! Take advantage of Anthem’s electronic solutions by signing up today for payments by electronic funds transfer (EFT). EFT helps you streamline your operations and reduce your administrative costs.

Consider these benefits:

- Reimbursements are deposited to your account faster
- EFT payments don’t get delayed or lost in the mail
- EFT payments are more protected from fraud
- Bank fees are lower
- You save time by making fewer trips to the bank
- Setting up EFT is a fast and reliable method to receive payment and you will incur no fees. You can
sign up using the CAQH EFT EnrollHub tool – or you can sign up via the Availity Portal (Availity). Also on Availity, you can access a detailed explanation of payment for each transaction and register to receive email notification for electronic payments. If you wish, you can elect to receive an email notification each time a payment is made to you.

**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 other than through Anthem, check with them for the correct value (code) for Anthem Blue Cross claims. Do not use any Payer ID that starts with “BS”. Your claim will route to Blue Shield and identify as out-of-network.
- 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

**E-Solutions support reminders**

Who do I contact for assistance with electronic data interchange (EDI) transactions?

- If you use a clearinghouse for claim submission, please make them your first point of contact.
- If you submit directly or are referred to Anthem, our knowledgeable and experienced E-solutions help desk associates are available.

What self-service tools and resources are available?

- Availity or other electronic options to check eligibility and claims status.
- Check your Level II report for EDI submissions daily to review and resolve any rejections.
I have tried the self-service options but still require further assistance

<table>
<thead>
<tr>
<th>E-Solutions EDI website</th>
<th>anthem.com/edi</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Solutions EDI online support mailbox</td>
<td><a href="mailto:E-Solutions.support@anthem.com">E-Solutions.support@anthem.com</a></td>
</tr>
<tr>
<td>E-Solutions Help Desk</td>
<td>1-800-470-9630 (toll free)</td>
</tr>
</tbody>
</table>

Network

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
- Medi-Cal Behavioral Health - BHMedi-CalNetworkRelations@anthem.com
- EAP - EAPProviderNetworks@anthem.com
- Commercial Medical – CACContractSupport@anthem.com (Non-Behavioral Health physicians)

ID card prefix changes

We mentioned in previous newsletters that there are a limited number of unused three-character, alpha-only prefixes for ID cards remaining. We have begun assigning prefixes that contain a combination of letters and numbers, or alpha-numeric prefixes. What does prefix changes mean to you?

- It is even more important to ask your patients for their most recent member ID card.
- When submitting claims, enter the identification number exactly as it appears on the member ID card.
- Check your EDI software 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”.
- 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.
Electronic member ID cards

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

Download the Anthem BC Anywhere app today.

Members can receive hard copies of their ID cards, even if they utilize an electronic version. They now have the option to choose electronic cards only. If the member chooses this option, a hard copy card will not be received. If it is their preference, members still have the option of selecting a hard copy.

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 Anthem BC Anywhere, mobile app will have the option to email or fax their ID card from their phone, and providers can view the ID card from the Availity Portal (print capability targeted for January 2018). Members are still required to have a copy of their card in one format or another, whether hard copy or electronic.

Anthem members that have this option

- Individual Commercial members as of fall 2017 for plans becoming effective on or after January 1, 2018. (This includes all plans on and off exchange.)
- Most Small Group members 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

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 the Availity Portal (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, and on Availity, select Payer Spaces > Education and Reference Center for educational resources.

Is authorization needed to see a member for ABA?

Most plans require pre-authorization for Applied Behavior Analysis (ABA) services. Only those ABA services and CPT codes for which authorization has been given will be covered. Any codes billed without an authorization are not allowed. Refer to Exhibit B, Payment Schedule, commonly known as your fee schedule, for allowable ABA CPT codes and the CPT manual for detailed information about each ABA CPT code. The codes billed should also be part of the preauthorization, which can be easily obtained using ICR via Availity. If you prefer, hard copy forms are available here.

Can associates (interns), physician or psychological assistants render services?

No. Participating commercial Behavioral Health providers are required to personally render covered
services to Anthem members. Services rendered by associates (prior to January 1, 2018 marriage and family therapists and professional counselors associates were called, interns) and assistants aren’t covered, even if supervised by the licensed provider.

**Note:** If you are also contracted with Medi-Cal, that is a separate agreement and contract terms may be different.

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.

**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*.

![Search as a Guest](image)

5. A new window will open. Enter information in the fields as shown below.

![Find a Doctor](image)

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 send an email to CABHNetworkRelations@anthem.com.

Follow steps listed below to submit practice changes:

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

Example:

![Email example]

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.

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:

- Email address
- Phone and fax number
- Check/EOB/billing/reimbursement address
- Open/closed practice status
Mailing/correspondence address
Practice/service address

TaxID (include a W-9 form with your change)

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 Updates for time frames 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.

**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 Provider Network Education page accessible through anthem.com/ca.

**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 eUPDATESs, 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 Blue Cross (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. From the top navigation bar find the Payer Spaces tab, and select Anthem Blue Cross from the drop-down menu.
3. Choose Education and Reference Center.
5. The list of documents displays. Select Network Leasing Arrangements

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 if you 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.

Updated Medical Treatment Utilization Schedule for Workers’ Compensation

The Division of Workers’ Compensation (DWC), per Labor Code, has updated the California Medical Treatment Utilization Schedule (MTUS) to the most recent American College of Occupational and
Environment Medicine Medical Treatment Guidelines (ACOEM). The updates include changes some of the section titles. Guidelines are being deleted as these subjects are addressed in other Guidelines. The ACOEM Guidelines are available from the Reed Group, the publisher of the ACOEM Guidelines. All physicians working with Workers’ Compensation (WC) patients should be aware that changes have been made and that the revised ACOEM Based MTUS will apply for procedures and treatment after December 1, 2017.

**Workers’ Compensation formulary transition in effect**

Physicians were required to provide a plan for replacement and weaning of previously prescribed drugs inconsistent with the MT US and Formulary by April 1, 2018. Anthem Blue Cross (Anthem) monitors “quality” pursuant to §9767.3(d)(8)(S) of the MPN regulations for MPN clients/payors. California Code of Regulations Section 9792.27.3. MTUS Drug Formulary Transition (b) (1) For injuries occurring prior to January 1, 2018, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a non-exempt drug or unlisted drug where that is necessary for the injured worker’s condition or necessary for safe weaning, tapering, or transition to a different drug.

- DWC Formulary Regulations: [dir.ca.gov/dwc/DWCPPropRegs/MTUS-Formulary/MTUSFormulary.htm](dir.ca.gov/dwc/DWCPPropRegs/MTUS-Formulary/MTUSFormulary.htm)
- Drug List: [dir.ca.gov/dwc/DWCPPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.xls](dir.ca.gov/dwc/DWCPPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.xls)
- DWC email address for questions regarding the formulary: [formulary@dir.ca.gov](mailto:formulary@dir.ca.gov)

**Guidelines and Quality Programs**

**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](mailto:Privacy Notice), and associated Health Insurance Portability and Accountability (HIPAA) standards.

**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 (collectively, the “Timely Access Regulations”). 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 time frames (also referred to as the “time elapsed standards” or “appointment wait time standards”). 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. Review this information with your staff so they are prepared and understand the importance of each provider’s 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>Emergency Care Instructions</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)</td>
<td></td>
</tr>
<tr>
<td>Non-Life Threatening Emergency Care</td>
<td>Appointment within 6 hours Members are directed to 911 or the nearest emergency room.</td>
</tr>
<tr>
<td>Urgent Care (does not require prior authorization)</td>
<td>Appointment within 48 hours Members are directed to 911 or the nearest emergency room.</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>15 Business days (Psychiatrists)**</td>
</tr>
<tr>
<td></td>
<td>10 Business days (Non-Physician Mental Health Care Providers)</td>
</tr>
<tr>
<td></td>
<td>5 Business days (EAP)</td>
</tr>
<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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</tbody>
</table>

**This date is 10 Business days for Psychiatrists when the appointment is an initial appointment due to accreditation standards.**

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](http://www.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 [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).

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

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 > Providers > Enter > Health & Wellness > Quality Improvement and Standards > Member Rights & Responsibilities

**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 > Communications to learn more.

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 though 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 though 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 the three-character alpha prefix.* Do not make up alpha prefixes. Claims with incorrect or missing alpha prefixes and/or member identification numbers cannot be processed.

*Due to a limited number of unused three-character, alpha-only prefixes, it’s expected that by mid 2018, alpha-numeric prefix identification numbers will begin to be distributed to members.

Overlapping service areas

Submission of claims in overlapping Blue Plan 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.

In other states, a company may carry the Blue Cross and Blue Shield name together, as a single entity. In California, there are two separate and independent Blue Cross Blue Shield companies. One is Anthem Blue Cross, and the other is Blue Shield of California.

- If you contract with both Plans in California, you may file an out-of-area Blue Plan member’s claim with either Plan.
- 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
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](#)
Behavioral Health Network Update, is published four times a year by Anthem Blue Cross for our contracted providers.

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