Behavioral Health Guide

Commercial Behavioral Health Individual Agreement

Note: Includes but is not limited to commercial HMO, PPO, on and off the exchange (Pathway), Medicare Advantage HMO and PPO Plans, and other plans designated by Anthem.

Thank you for participating in the Anthem Behavioral Health network!

As a participating commercial behavioral health provider in our network, you have 24/7 online access to specific tools and information.

Visit our **Behavioral Health Provider Resources** web page for information that will help you effectively manage your relationship with Anthem and save you administrative time and resources.

Download and save this interactive Behavioral Health Guide to your computer to ensure the guide functions properly. You will find links throughout that take you to information quickly. It is designed to answer day-to-day questions, introduce several resources, self-service tools, and provide valuable information about Anthem to our participating behavioral health providers.

We look forward to building a strong collaborative relationship with you. Together, we can deliver quality care to our members, provide greater value to our customers, and help improve the health of our communities.

Sincerely,
Behavioral Health Network Management
Anthem

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Overview

An individual agreement only applies to you, the care provider, who sees and treats our members. You are the sole (single) provider associated with your practice Tax ID. You have completed the credentialing process and have been assigned a contract effective date.

As a participating provider, you must abide by the responsibilities outlined in your Agreement, California Facility and Professional Provider Manual (Manual), updates to the Manual, and Behavioral Health Individual Guide.

Individually participating or contracted providers serve any Anthem plans that access the Behavioral Health network. This includes but is not limited to commercial HMO, PPO, on and off the exchange (Pathway), Medicare Advantage HMO and PPO Plans, and other plans designated by Anthem. This does not include the Medi-Cal Managed Care (Medi-Cal) Program or Anthem Medicare Supplemental plans, which are different agreements.

Members enrolled in the BlueCard Program (out-of-area) also access the Behavioral Health network. As a participating provider, you may render services to members who are National Account members of other Blue Plans and who travel or live in California.

Review this Behavioral Health Guide for answers to everyday behavioral health topics and resources.

Availity Essentials is our secure website, available 24 hours a day, seven days a week, except during scheduled maintenance and national holidays. It allows you to access real-time eligibility and benefits, claims status information, the Manual, fee schedules, online provider remittances, and more. Register at **https://Availity.com**.

Visit the Behavioral Health Provider Resources web page for more information.

General responsibilities

As a participating provider, you are responsible for sharing information with Anthem departments including Contracting, Credentialing, and Provider Relationship Account Management.

Behavioral Health Providers	
Educate yourself on Anthem processes	**Review:** • Contractual requirements of your Agreement. • Payment/Fee Schedule. Understand the services you are contracted for, what you are allowed to bill for, and the amount you will be paid. • Educational information (such as newsletters and the Manual) • Billing guidelines and process **Be sure to:** • Verify benefits and eligibility for each member. Behavioral health services may be handled by another payer and plans may require preapproval. • Collect only the copay, a percentage of the costs, or deductible. • Refer only to in-network or participating providers. • Log in to CAQH. Review and attest every 120 days to avoid network participation interruptions due to outdated information.
Notify us of practice changes	• Practice changes (tax ID, practice /mailing address) • Open or closed practice
Reference the resource guide	• Contacts for questions • Online resources and self-service tools
Abide by agreements, processes, and procedures	• Adhere to the terms in your Provider Agreement (contract). • Understand information in the Manuals. • Follow operational procedures outlined in the Behavioral Health Individual Guide.

Understanding your agreement

Your Behavioral Health Agreement with Anthem is individual and applies only to you, the provider seeing and treating our members. You are the only provider associated with your practice Tax ID.

Associates (interns), psychological, or physician assistants

SB 855 amends existing California mental health parity legislation and broadens access to care for mental health or substance use disorders. The bill expanded mental health services to include supervised providers (associates, interns, psychological or physician assistants). Anthem does not directly contract with these providers; however, they can render services to members if the supervising licensed provider is contracted with Anthem.

The claim form should only include the licensed, contracted provider information. Always verify member benefits and eligibility before rendering services.

Plans included in a Behavioral Health agreement

Participating providers serve any Anthem plan that accesses the Behavioral Health network. This includes but is not limited to commercial (HMO, PPO) plans and plans on and off the exchange (Pathway) and Medicare Advantage HMO and PPO Plans.

You may provide services to members who belong to other Blue Plans. The **BlueCard Program** (BlueCard) is a national program that enables members who travel or live in California to obtain healthcare service benefits in another Blue Plan's service area.

Plans not included in a Behavioral Health agreement

The Behavioral Health network agreement does not include the Employee Assistance Program (EAP), Medi-Cal plans, and Anthem's Medicare Supplemental plans.

Understanding your agreement (cont.)

Blue Shield of California

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: Anthem and Blue Shield of California.

Adding providers to an individual agreement

You cannot add a provider to an individual agreement. Your Agreement is specific to, and applies only to you, the individual provider named in the Agreement. You are the only provider associated with your practice Tax ID identified in the Agreement.

No-shows and cancellations

Anthem does not reimburse cancellations or no shows; however, we understand that some practices impose financial penalties for missed appointments. While not prohibited by your contract, we ask that you exercise compassion and consider your patient's medical condition before imposing a penalty. These policies must not be a barrier to access. Members can be accountable for no-shows only if the member has signed an agreement before rendering services, indicating informed willingness to personally accept financial liability prior to the no-show and if cancellation is not under the office's cancellation policy. Charges cannot exceed the contract rate.

Credentialing

Our Credentialing Program accesses information through CAQH ProView®. Credentialing data must be current, attested to, and Anthem authorized viewing rights. We require this for all providers contracted with the Behavioral Health network.

Recredentialing

Anthem's recredentialing policy requires review and verification of provider credentialing data every three years. About six months before the three-year mark, you will be notified that you are due for recredentialing.

Keep your CAQH application current. Attest every 120 days to avoid network participation interruptions due to outdated information (addresses, liability coverage, and more).

Your practice information on file must be current to receive notification. It is equally important that your CAQH application is current and attested to prevent termination for non-compliance.

Follow these steps to attest to your CAQH application:

1. Log in to CAQH ProView at **proview.caqh.org**.
2. Make sure all information is current and accurate.
3. Attest to your application after data verification.
4. Authorize Anthem viewing rights to access your information.
5. Upload and submit supporting documents.

All providers must be registered with **CAQHProview™**. Call the CAQH Help Desk toll-free at **888-599-1771** or email providerhelp@proview.caqh.org.

Seeing a member

Member ID cards

Members are required to have a copy of their card accessible, whether hard copy or electronic. If the member chooses to receive their ID card electronically, a physical copy will not be mailed. Member ID cards will display a three-character, alpha-only (letter) prefix or a combination of letters and numbers, known as an alpha-numeric prefix.

Mobile application

The Sydney℠ Health app is a no-cost Anthem app that allows members to conveniently manage their benefits on their smartphones, and it includes electronic copies of their ID cards. The Sydney app is available for iPhone and Android.

If presented with an electronic card, you may still obtain a copy for your records. The Sydney mobile app allows you to email or fax the ID card from the member's electronic device. You can also view the ID card on **https://Availity.com**.

Things to know before rendering any services:

- Confirm if the member is eligible for coverage.
- Confirm if preauthorization or preapproval of behavioral health services is required (if applicable).
- Always obtain preapproval prior to rendering ABA services.
- Confirm if the member accesses the Behavioral Health network for services.
- Confirm what the copay, coinsurance, or deductible is.
- Collect the copayment, coinsurance, and deductible from the member.
- Know where claims should be submitted.
- Bill Anthem directly for services. We recommend that claims be submitted electronically.

Benefits and eligibility

Member plans and services vary and may change. Verify benefits, eligibility, copay information, and authorization requirements before rendering services. In this guide, read more about authorization under the subheading, Authorization. Behavioral health services may be handled by another payer, and some plans require authorizations.

ABA-specific benefits: If the member's plan has not yet been updated with these benefits, ask or look for the member's "professional nervous and mental benefits," including deductible and copay.

Benefits, eligibility, and authorization requirements can be verified on **https://Availity.com** or by calling the toll-free number on the back of the member's ID card.

Refer members (patients) in-network

Per your agreement, refer only to in-network or participating providers. Referring to an out-of-network provider is not allowed. To find a participating provider, use Anthem's online provider directory. Visit **https://www.anthem.com/ca/provider** and select **Find Care**.

Authorization

Verifying authorization requirements when confirming benefits and eligibility and whether mental health services are handled through Anthem is important. Authorization requirements vary depending on the service and each member's plan.

When services require preapproval use Interactive Care Reviewer (ICR) on Availity Essentials to streamline the process at no cost.

BlueCard (out-of-area)

The BlueCard Program lets you conveniently submit claims for other Blue Plans, including international Blue Plans, directly to Anthem. You can render services to a BlueCard member if their benefits allow it. Verify benefits and eligibility for BlueCard by contacting Provider Services via the number on the back of our member ID card. Visit the **BlueCard Provider Program Manual** for more information.

Carve-out services

Some plans may provide medical services but not coverage for mental health services. These services are carved out or managed by another service or company. This is identified when verifying benefits or information, which is usually listed on the member ID card, including the name and number to call for behavioral health services.

This is not included in your agreement, and for the services to be covered, you must participate in-network with the other service or company.

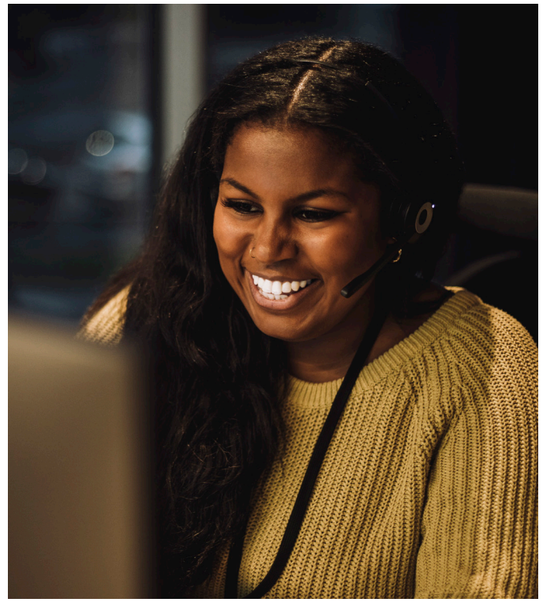
Network leasing arrangements

Anthem has network leasing arrangements with various organizations, which we call Other Payors. These payors and affiliates use our 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 additional charges from the doctor.

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

1. Log in to **https://Availity.com**.
2. From the top navigation bar, find the *Payer Spaces* tab and select **Anthem** from the drop-down menu.
3. Choose the tile, **Information Center**.
4. A new window will open. Select **Administrative Support**.
5. A list of documents displays. Select **Network Leasing Arrangements**.



Availity Essentials

Availity Essentials is a secure website available at no charge to participating providers. Information on **https://Availity.com** is updated in real time; get the same information you would receive by calling Customer Service. Check member benefits, eligibility, deductibles, and claims status easily online. You also have access to policies and educational resources, manuals, forms, the ability to research procedure code edits, electronic transactions, remittance advice, and much more.

To register, go to **https://Availity.com** and select **Register**. For detailed instructions on navigating the website, select **Help & Training** from the top navigation menu on the Availity Essentials website.

Note: Google Chrome is the recommended web browser. Do not share login information; each staff member must have an individual login.

If you have any questions, call Availity Client Services toll-free at **800-282-4548** Monday to Friday, 5 a.m. to 5 p.m. PT.

Utilization management

We administer a Utilization Management (UM) program to determine whether services provided to members are medically necessary.

Medical necessity criteria are the policies and Clinical Guidelines that UM and care management staff use. For questions on these criteria, call UM toll-free at **800-274-7767**.

In addition to the documents that we develop and maintain for coverage decisions, we may adopt clinical utilization management criteria (UM guidelines) developed and maintained by third-party organizations.

To determine which clinical UM guidelines have been adopted, customized, or if there are applicable third-party criteria, visit **https://www.anthem.com/ca/provider** to read about our Medical Policies and guidelines.

Interactive care reviewer

Using the innovative technology of ICR, you can save time when submitting authorization requests and clinical information and receive status on your request through Availity Essentials. Visit the **https://www.anthem.com/ca/provider** and select **Prior Authorization** for more information.

Billing and claims

This section provides general guidelines and requirements for the Behavioral Health network, in order to appropriately bill and submit claims.

Claim submission process

Electronic submission is preferred. Paper claims should be submitted to the mailing address on the member's ID card.

Electronic data interchange

Claim submission via electronic data interchange (EDI) is a safe, secure, and HIPAA-compliant way to transfer information. EDI claims are faster and more accurate. EDI is the preferred method for submission. Availity Essentials manages all of our electronic data and transactions, including electronic remittance advice. Avoid postal delays and the costs of mailing by transmitting your claims 24/7 via **https://Availity.com**.

For additional information about electronic claims submission and other electronic transactions, including electronic funds transfer (EFT) and electronic remittance advice (ERA), visit our **EDI webpage**. You will also find helpful information in the **manual**.

General billing guidelines

- Use the Anthem payer ID code 47198 when submitting electronic claims.
- If you submit through a clearinghouse or use a software vendor, check with them for the correct value (code) for Anthem claims.
- ICD-10-CM (ICD-10) diagnosis codes must be used for billing.
- Refer to the current ICD-10 Codes Manual for appropriate codes.
- Use the current CMS-1500 form.
- Include the individual NPI of the rendering provider.
- Provide all member information, including the complete member ID number with the three-character alpha-only or alpha-numeric prefix information on the claim.
- Rendering provider's name
- Rendering provider's NPI (the rendering provider should be the provider named in the authorization)
- Submit original claims within 90 days of performed services.
- Note: When behavioral health benefits are carved out to another health plan, timely filing limits may be different than those in your agreement, so the timely filing limits may differ from those in your Agreement.
- Always bill referring to the fee schedule which includes the allowable behavioral health and ABA CPT® codes. The CPT manual can be used for detailed information about each CPT code.

Where and how to submit BlueCard Program claims:

- Always Submit BlueCard claims to:
  Anthem
  P.O. Box 60007
  Los Angeles, CA 90060-0007
- Include the member's complete ID number when submitting the claim:
  - The complete ID number includes the three-character prefix.
  - Incorrect or missing information delays claims processing.
- Once we receive the claim, it will electronically route to the member's Anthem plan.
- We will work with the member's plan to process the claim:
  - The plan will send an explanation of benefits to the member.
  - We will send you payment or the remittance advice, and issue the payment to you under the terms of our contract with you and based on the member's benefits and coverage.

Claim issue resolution

Send an online secure message through Availity Essentials or call the number on the back of the member's ID card for questions about a claim.

Secure messaging: Availity Essentials provides the opportunity to ask a question about a claim online. Send a detailed question to clarify the status of a claim or to get additional information on a claim. This offering is only available at **https://Availity.com**. Secure messages can be sent to local Anthem, BlueCard out-of-area, and Federal Employee Program® (FEP®) member claims.

Customer service: When calling Customer Service have the member ID number, date of birth of the patient and claim number (DCN) and at the end of your call you will receive a reference number.

Please do not use Secure Messaging to respond if you received a bar-coded mail-back letter regarding a claim. Instead, place the mail-back letter on top of the requested information and follow the mailing instructions.

If the issue remains unresolved, ask for a supervisor. If that does not resolve your issue, submit a provider dispute.

Submit a provider dispute

The **Provider Dispute Resolution Request** form is used to initiate the formal dispute process for a claim that has already been adjudicated or when a provider disagrees with an Anthem billing determination. To learn more about our dispute process, access the **Supplemental Education Materials**.

Practice changes

Notify Anthem Provider Database Management in writing of any addition, deletion, or update to your practice within 30 days of such change. This includes updating mailing, billing (remit), or practice addresses, phone numbers, tax ID, accepting new patients status, and more.

Note: California law requires that participating healthcare providers notify health plans within five days when their Accepting New Patients status changes.

Providers contracted with Anthem should use the Provider Data Management (PDM) application at **https://Availity.com** to request changes to existing practice information and more.

Follow these steps to submit practice changes:

1. Log in to **https://Availity.com**.
2. Select **My Providers**, then **Provider Data Management** to begin using PDM.
   Note: Do not select **Manage My Organization**.
3. If you do not see Provider Data Management, you must get access. Contact Availity Client Services to get access.
4. If you have technical questions, call Availity Client Services at **800-AVAILITY** (**800-282-4548**) toll-free.

Tax ID, name, or license changes

Please email your Tax ID, name, or license change requests to the California Network Development team at CANetworkDevelopment@anthem.com.

Terminating your individual agreement

To terminate your Agreement, you must submit a signed and dated letter to the Anthem California Network Development team for processing. A resignation requires 120 days' prior notice, depending on your contract language. The termination letter must:

- Be on your practice's letterhead.
- Be signed and dated by the provider (owner of the agreement).
- Include the reason for terminating the agreement.
- nclude your tax ID and NPI number.

You will receive an email confirmation of your resignation date.

Note: As a terminating provider, during this 120-day notification period, you are required to notify your Anthem members of your termination date, complete your patients' care, and transition them to participating providers. Your patients also have the option to remain in your care as a self-pay client.

Email the California Network Development team at CANetworkDevelopment@anthem.com for resignations, status, and questions regarding your resignation.

FAQ

What plans are included in my Agreement?

Once approved by Anthem, participating providers serve any plans that access the Behavioral Health network. This includes but is not limited to Commercial HMO, PPO, on and off the exchange (Pathway), Medicare Advantage HMO and PPO Plans, and other plans designated by Anthem.

How do I update a tax ID, name, or license?

An amendment or contract change is required. Email the California Network Development team at CANetworkDevelopment@anthem.com. Include a signed W-9 form for Tax ID changes.

What is the claim submission process?

Electronic submission is the preferred method. Direct deposit (EFT) is also available. Paper claims (not recommended) should be submitted to the mailing address on the member's ID card.

How do I sign up for Direct Deposit (EFT)?

Electronic Fund Transfer or direct deposit, services are handled by **EnrollSafe**. Email the EnrollSafe help desk at Support@payeehub.org or view the **Support Guide** for assistance. Providers requesting an issue to be escalated can contact the EnrollSafe Payee HUB Support toll-free number at **877-882-0384** and request to speak to a supervisor or manager.

How are claim issues resolved?

Send an online secure message through Availity Essentials or call Customer Service. When calling Customer Service, have the member ID number, claim number (DCN), and prior call reference number (if available). If the issue remains unresolved, ask for a supervisor. If the issue is not resolved with a Customer Service Representative or supervisor, submit a provider dispute.

After submitting a provider dispute, you will receive written acknowledgment including a reference number. For more information, refer to the Provider Dispute Resolution process in the provider manuals.

How does re-credentialing work?

Our recredentialing policy requires review and verification of provider credentialing data every three years. You'll be notified about six months before the three-year mark that you are due for recredentialing. Keep your CAQH application current. Attest every 120 days to avoid network participation interruptions due to outdated information (such as addresses or liability coverage)

Resources

Contact Anthem Behavioral Health at:

- Application or request status — Log in to **https://Availity.com** and go to the dashboard.
- Visit the **Contact Us** page at **https://www.anthem.com/ca/provider** for questions about adding a provider to your existing commercial BH or ABA group access.
- Questions about new commercial BH or ABA individual (solo) or group email CANetworkDevelopment@anthem.com
- Visit the **Contact Us** page at **https://www.anthem.com/ca/provider** for general questions

Online resources and self-service tools:

- **Anthem website**
- Provider manuals can be accessed at **https://Availity.com** or **https://www.anthem.com/ca/provider**.
- Availity Essentials, a secure platform for Anthem eligibility, benefits, claim status inquiry, demographic or practice updates, manuals, authorization requests and more.
- Bookmark **Behavioral Health Provider Resources**, a consolidated behavioral health-specific website.
- For a list of service departments and contact information, visit the **Contact List of Departments**. Additional website resources can be found under the *Links* section of the manual.

Glossary

There are terms and abbreviations used throughout this guide and in the process of conducting business with Anthem that represent company and healthcare industry concepts and services. To help you understand the terminology, the following is a glossary of terms. Other terms are available in the Glossary section of the manual.

Behavioral Health Carve-out: Some employers choose Anthem for medical services and carve out behavioral health services to other health plans. A member may present a Blue Cross Blue Shield member ID card but will have behavioral health benefits with another company.

Benefits: The types of care or services an insurance plan will pay for certain types of medical or behavioral health services.

CAQH: An online provider data-collection solution used by Anthem for credentialing and other services. It streamlines provider data collection by using a standard electronic form that meets the needs of health plans, hospitals, and other healthcare organizations.

CMS-1500: The most current health insurance claim form.

Coinsurance: An arrangement under which the insured person pays a fixed percentage of the allowable cost of medical care after the deductible has been paid.

Copayment or Copay: A type of member cost sharing that requires a flat amount per service.

Deductible: The amount of charges some members must pay for any covered expense before selected benefits are available under their plan. The member's deductible is stated in his or her plan.

Document Control Number (DCN): A system-assigned number once a claim is submitted for reimbursement. The number is used in claims follow-up and may be referred to as the "Claim Number."

Electronic Data Interchange (EDI): Computer-to-computer transfer of transactions and information. Electronic billing is a component of EDI.

Electronic Remittance Advice (ERA): An electronic version of the EOB. Print or automatically post payments utilizing practice management software.

Electronic Funds Transfer (EFT): An option offered by which claim payments can be directly deposited into a provider's financial institution account.

Explanation of Benefits (EOB): A written summary of the processing of a healthcare claim, sent to the provider of services and the member.

Evidence of Coverage (EOC): A complete listing of a member's benefit plan as structured by the employer. The EOC is commonly known as the Member Benefit Booklet.

HCID: Health Care Identification Number. Otherwise known as the member ID.

National Provider Identifier (NPI): A unique 10-digit number issued by CMS to healthcare providers. Anthem requires an NPI for all provider types.

Participating Provider: A hospital, other health facility, physician, or other health care professional that has an agreement with Anthem to provide health care services for prospectively determined rates.

Pathway and Pathway X Plans: Anthem names for the Affordable Care Act-compliant plans, offered on the Covered CA Exchange (Pathway X), and by Anthem directly (Pathway). Generally, this is for individual members but also applies to some Small Group plans.

Third-party Administrator (TPA): Some employers use TPAs to manage benefits and eligibility and/or process claims. The address and phone number for TPAs will be on the member's ID card. See the definition for Other Payors in the Manual. For a list of Other Payors (Network Leasing Arrangements), visit **https://Availity.com**.

Tracking Number: A system-assigned number to a call into Customer Service or Provider Care. This number refers to call documentation and is also the same as Inquiry Tracking Number.

Learn more about Anthem programs

https://www.anthem.com/ca/provider

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