California | Anthem Blue Cross
Medi-Cal Managed Care

Non-specialty mental health services

Provider training

CABC-CD-076303-25 | February 2025

California's bifurcated Medi-Cal Managed Care behavioral health system

Our non-specialty mental health services (NSMHS)

Mental health services provided by licensed professionals (as defined in the Medi-Cal Managed Care provider bulletin) acting within the scope of their license:

- Mental health evaluation and treatment, including individual, group, and family psychotherapy, ABA
- Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements

Note: No approval required for outpatient therapy and psychiatry (required for out-of-network therapy/psychiatry providers only); preapproval required for ABA, psychological/neuropsychological testing.

SMHS — county outpatient:

- Assessment
- Plan development
- Therapy
- Collateral
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis residential treatment
- Adult residential treatment
- Crisis intervention
- Crisis stabilization
- Targeted case management
- Intensive care coordination
- Intensive home-based services
- Therapeutic foster care
- Therapeutic behavioral services

— county inpatient:

- Acute psychiatric inpatient hospital services
- Psychiatric health facility services
- Psychiatric inpatient hospital professional services if the beneficiary is in fee-for-service hospital

Behavioral health eligibility criteria

All members who contact Anthem or the County BH Teams are screened to determine severity of symptoms based on the outcome of the DHCS standardized screening tool:

- If the member scores in the range for **non-specialty mental health** criteria or functional impairments, the member is referred to an Anthem contracted provider for NSMHS.
- If the member scores in the range for the **specialty mental health** criteria or impairments, the member is referred to the MHP County BH team.

The services of NSMHS

Service	Description	Common providers
Mental health evaluation and treatment, including individual, group, and family psychotherapy	Initial assessment (also known as a diagnostic assessment) or biopsychosocial assessment and ongoing psychotherapy sessions to ameliorate distressing symptoms of behavioral health conditions through empirically based practices and goal-focused interventions.	• Licensed masters-level behavioral health therapists (LCSW, LMFT, LPCC) • Licensed doctoral-level behavioral health clinicians (psychologists) • Primary care and medical staff working within the capacity of their training, education, and licensure
Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition	Psychological and neuropsychological testing (also known as psychological assessment or evaluation) is a series of tests to evaluate a person's mental, behavioral, and cognitive functioning. The purpose of such an evaluation is to ensure clarity diagnostically and to ultimately provide for the best care plan for each individual when there is uncertainty or clinical inquiry.	• Licensed doctoral-level behavioral health clinicians (psychologists) • Licensed psychiatrists working within the capacity of their training, education, and licensure
Psychiatric consultation	Initial assessment and ongoing monitoring of psychotropic medications as indicated for effectiveness in the treatment of behavioral health conditions. Psychiatrists evaluate for diagnoses, symptoms, and impairments and prescribe medications to address their findings. Patients are monitored ongoing to ensure effectiveness and safety/side effects of the medications.	• Licensed psychiatrists working within the capacity of their training, education, and licensure • Primary care and medical staff working within the capacity of their training, education, and licensure
Outpatient laboratory, drugs, supplies, and supplements	Supportive necessary supplies and supplements for physician-administered drugs administered by a healthcare professional in a clinic, a physician's office, or an outpatient setting through the medical benefit to assess and treat behavioral health conditions	• Licensed psychiatrists working within the capacity of their training, education, and licensure • Primary care and medical staff working within the capacity of their training, education, and licensure

Licensed mental health professionals

The responsibilities of the licensed mental health professional (LMHP) and the requirement for Anthem to provide and arrange for the provision of NSMHS

These services are provided to:

- Members who are 21 years of age and older with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders as defined by the current *Diagnostic and Statistical Manual of Mental Disorders.*
- Members who are under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment or the presence of a diagnosis.
- Members of any age with potential mental health disorders not yet diagnosed.
- Services that are *medically necessary* or a *medical necessity* in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS, are covered by us as EPSDT services.
- Members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder are subject to psychotherapy.
- Pregnant and postpartum individuals with specified risk factors for perinatal depression: We will cover up to 20 individual and/or group counseling sessions when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.

Primary care providers and medical staff within competency

The responsibilities of the PCP for outpatient mental health services within their scope of training and practice

PCPs are responsible to provide services, including:

- Screening for mental health conditions (EPSDT, ACES, Depression PHQ-2 or PHQ-9, and so on).
- Screening and brief intervention for substance use conditions (SABIRT screening).
- Referrals for additional assessment and treatment.
- When applicable, medical histories, medical consultations, and physical exams in association with an inpatient mental health admission (required within 24 hours of admission).
- Members with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within our network.
- In situations when the member's PCP cannot perform the mental health assessment, the PCP must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in our provider network or the county mental health plan's network.
- At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within our provider network.

TeleBH — behavioral health telehealth options

We have a robust network of behavioral health providers and treatment modalities include both in person and telehealth.

Members wishing to receive their NSMHS via telehealth have multiple options:

- Many of our BH providers offer both options — in person and telehealth:
  - Using the Find a Provider tool, members can identify a provider whom they feel is a strong match to their clinical needs and unique preferences.
  - PCPs can assist members in this search on our website for those who would benefit from assistance in navigating this tool.
- Members/providers can always call our Behavioral Health Call Center for assistance in appointment search/provider list provision: **800-407-4627**
- LiveHealth Online offers virtual therapists, psychologists, and psychiatrists with appointments available seven days a week at no cost. The app can be used on a smartphone, a tablet, or a computer: https://livehealthonline.com

Crisis support and emergency services for behavioral health/substance use disorder

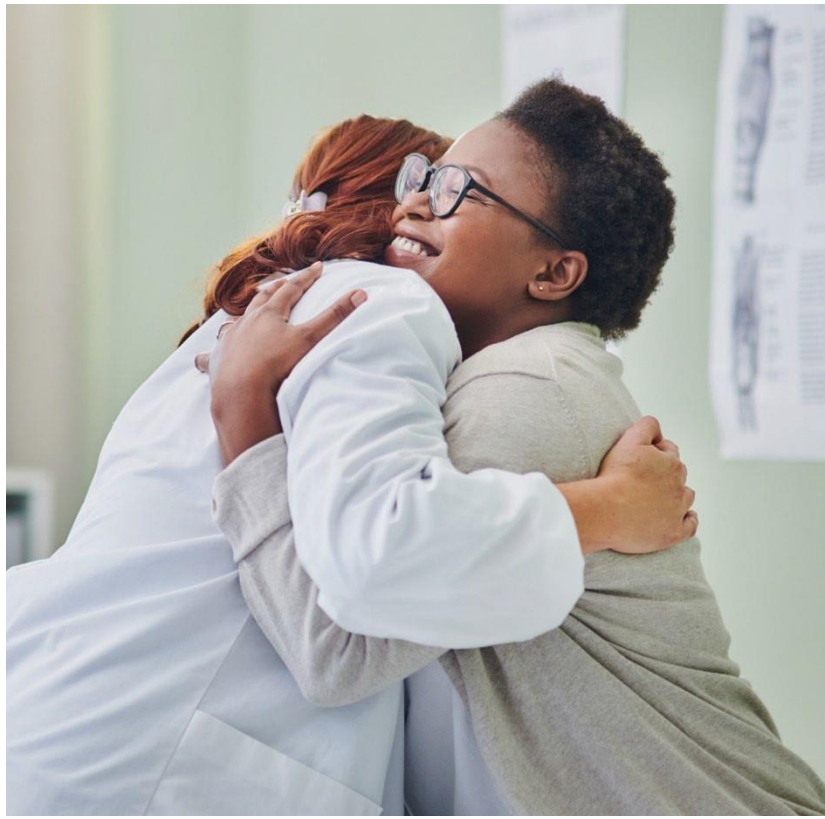
We appreciate that life can become very challenging at a moments notice. It is essential that our PCPs and providers reinforce the multiple crisis supports that PCPs, LMHPs, the health plan, and our state of California provide.

Providers	Anthem	Emergency room support for BH/SUD	988 Lifeline California's crisis line
Our Licensed Mental Health Professionals (LMHPs) by contractual agreement must be available to our members 24/7 by telephone **or** have an arrangement with an on-call provider to cover when the LMHP is not available.	Ensures clinical support to members around the clock for crisis support 24/7/365. Any member who calls us and is in need of immediate intervention is connected to one of our behavioral health clinicians for immediate evaluation and support.	Emergency services necessary to stabilize the member; we will cover and pay for ER professional services as described in Section 53855 of Title 22 of the *California Code of Regulations*, including screening examinations necessary to determine the presence or absence of an emergency medical condition.	988, the Suicide and Crisis Lifeline, understands that life can sometimes be difficult. Whether a member is facing mental health struggles, emotional distress, alcohol or drug use concerns, or just needs someone to talk to, counselors are here 24/7/365. Conversations are free and confidential.

How does a member access behavioral health services?

Members can contact:

- County BH
- Anthem call center
- Anthem providers



No Wrong Door coordination and nonduplication expectations

Concurrent NSMHS and SMHS

Members may concurrently receive NSMHS from our provider and SMHS via a county provider when the services are clinically appropriate, coordinated, and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. We will not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated, and not duplicative.

Established therapeutic relationships

Members with established therapeutic relationships with our provider may continue receiving NSMHS from our provider, even if the member simultaneously receives SMHS from a county provider, as long as the services are coordinated between the delivery systems and are nonduplicative (for example, a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).

Continuity of care (COC)

We will allow, at the request of the member, authorized representative, or provider, up to 12 months of COC with an out-of-network mental health plan provider in accordance with the COC requirements. After the COC period ends, the member must choose a mental health provider in our network for NSMHS.

Consistent with clinical best practice, all treatment providers caring for a member should be aware of one another other and the treatment being provided to ensure member permission, nonduplication of care, and noncontraindication of treatment through a highly collaborative partnership. The PCP is honored as the lead in coordination of all care for their member.

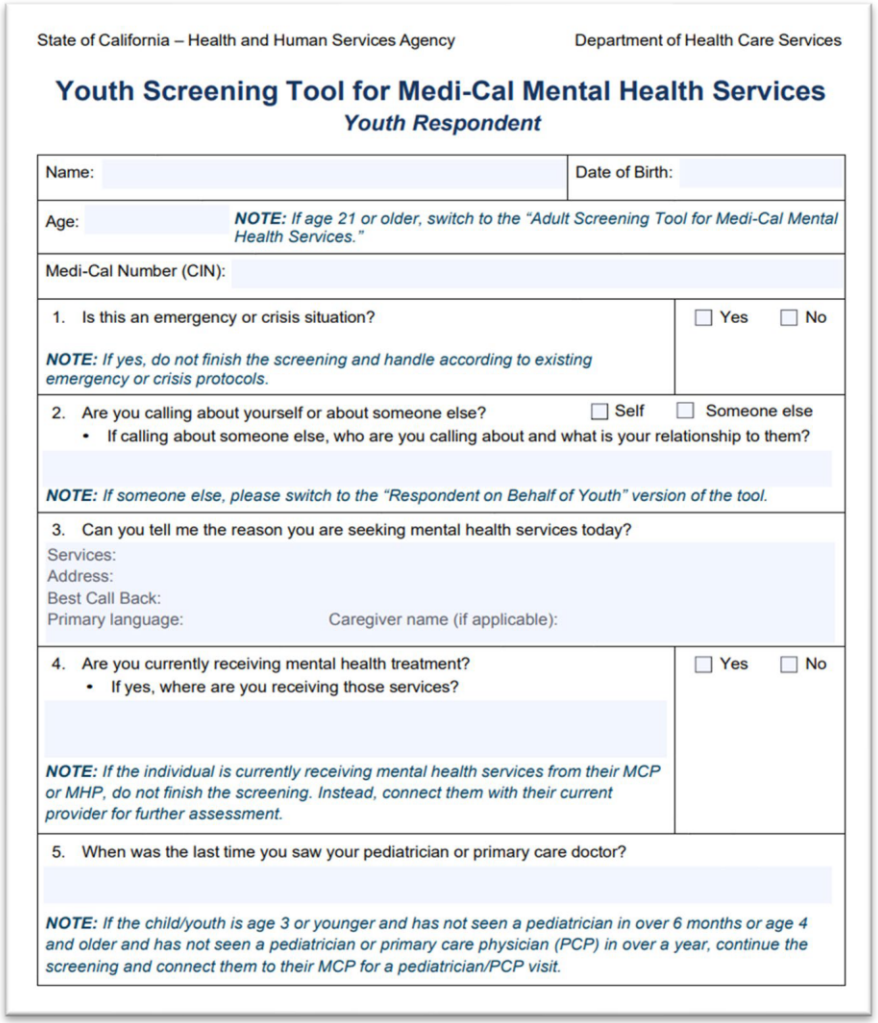
Screening and transition of care tools

Screening tools

Statewide implementation of the screening and transition of care tools for Medi-Cal Managed Care mental health services became effective January 1, 2023. DHCS developed standardized adult and youth screening tools to determine the most appropriate Medi-Cal Managed Care mental health delivery system referral.

The adult screening tool for mental health services is required for use when an individual age 21 or older, who is not currently receiving mental health services, contacts the Medi-Cal Managed Care plan (MCP) or the county mental health plan (MHP) to seek mental health services.

The youth screening tool for mental health services is required for use when an individual under age 21, or a person on behalf of an individual under age 21, who is not currently receiving mental health services, contacts their MCP or the county MHP to seek mental health services.



State of California – Health and Human Services Agency Department of Health Care Services

Youth Screening Tool for Medi-Cal Mental Health Services

Youth Respondent

Name: Date of Birth:

Age: ***NOTE:*** *If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*

Medi-Cal Number (CIN):

1. Is this an emergency or crisis situation? ☐ Yes ☐ No

NOTE: *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

NOTE: *If someone else, please switch to the "Respondent on Behalf of Youth" version of the tool.*

3. Can you tell me the reason you are seeking mental health services today?

Services:
Address:
Best Call Back:
Primary language: Caregiver name (if applicable):

4. Are you currently receiving mental health treatment? ☐ Yes ☐ No
   - If yes, where are you receiving those services?

NOTE: *If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*

5. When was the last time you saw your pediatrician or primary care doctor?

NOTE: *If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Screening tools (cont.)

Both the adult and youth screening tools have yes/no questions. Not every question is scored. Each scored question has a defined set of points:

- Adult tool: 14 questions
- Child/youth (two versions, one for youth respondents and another for respondent on behalf of youth): 23 questions.

The yes answers are totaled. The total score determines if the member is referred to MCP or MHP (County) for a clinical assessment:

- Total score of 0 to 5 must be referred to the MCP (nonspecialty) for clinical assessment.
- Total score of 6 or more must be referred to MHP (county, specialty) for clinical assessment.

There is an SUD question that does not impact the screening score. If the member responds yes, a referral must be offered to MHP.

If the score indicates referral to the other delivery system (from MCP to MHP or vice versa), a referral is coordinated. This includes sharing the completed screening tool form and follow-up to ensure timely assessment/intake.

Adult and youth screening tools are not required when members contact mental health providers directly to seek mental health services. (See next slide.)

Screening tools (cont.)

The adult and youth screening tools are not administered by Anthem contracted providers.

> "The Adult and Youth Screening Tools are not required to be used when Members contact mental health providers directly to seek mental health services. Anthem must allow contracted mental health providers who are contacted directly by Members seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in *APL 22-005*."
>
> — *APL 22-028,* page 7

Outpatient mental health services are open access within our network. There is no requirement for a preapproval (PA) or a registration number for services to be rendered by an in-network provider. **PA is required for covered services by an out-of-network provider.**

In accordance with No Wrong Door (*APL 22-005*), NSMHS coverage includes:

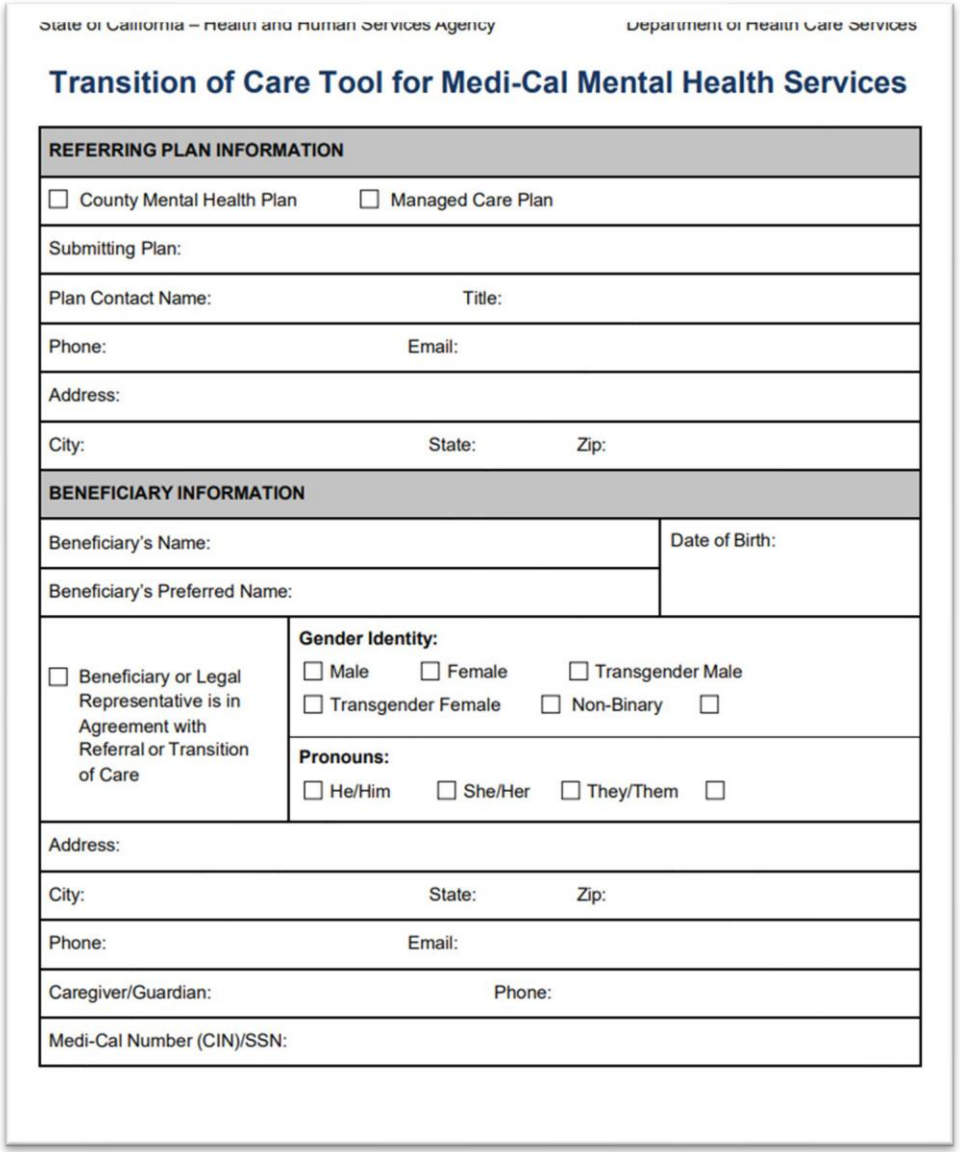
- Reimbursement for services provided during the assessment period, including scenarios in which members meet criteria for services from the county.
- Members receiving services at both levels of care as long as services are coordinated and nonduplicative.
- Substance use diagnosis when billed with a mental health diagnosis on a claim.

Transition of care tool

The transition of care tool for Medi-Cal Managed Care mental health services leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Anthem plan (MCP) or county mental health plan (MHP) as needed.

The tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and either:

- Their existing services need to be transitioned to the other delivery system; or
- Services need to be added to their existing mental health treatment from the other delivery system.



State of California – Health and Human Services Agency Department of Health Care Services

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION		
☐ County Mental Health Plan ☐ Managed Care Plan		
Submitting Plan:		
Plan Contact Name:	Title:	
Phone:	Email:	
Address:		
City:	State:	Zip:
BENEFICIARY INFORMATION		
Beneficiary's Name:		Date of Birth:
Beneficiary's Preferred Name:		
☐ Beneficiary or Legal Representative is in Agreement with Referral or Transition of Care	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary ☐	
	Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐	
Address:		
City:	State:	Zip:
Phone:	Email:	
Caregiver/Guardian:	Phone:	
Medi-Cal Number (CIN)/SSN:		

Transition of care tool (cont.)

The transition of care tool:

- **Does not** need to be used for referrals within the same delivery system. For example, the member is already receiving therapy services from our provider and needs prescriber services from another one of our providers.
- **Does not** constitute or replace clinical assessments.
- **Does not** determine whether an individual needs to transition (determination must be made by a clinician, and the tool itself is the tool used for making the referral).

The transition of care tool:

- **Does** support referrals when transitioning care to or adding a service from the other mental health delivery system.
- **Does** support standardized sharing of existing clinical information.
- **Does** need to be used by MCPs, such as Anthem, and MPHs (County).

How to request member transition of care

To request transition of care or add a nonduplicative service with the county mental health plan (MHP) for a member, the treating Anthem provider may fax the completed transition of care form to **855-473-7902** or send the completed form to us by email at bhcmreferrals@anthem.com.

An Anthem licensed case management clinician will complete a review of the member's clinical information on the form with the provider via phone to confirm that the member requires a transition or addition of a service with the MHP delivery system.

If member requires a transition or addition of a service, our licensed case management clinician will send the transition of care form based on the clinical information entered on the form and the information confirmed/gathered during the provider phone interview.

Our provider discusses the transition to the MHP delivery system with the member and obtains consent for the transition. The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician via a patient-centered, shared decision-making process.

Our provider continues to treat the member until the transition is complete; our staff sends the transition of care form to the MHP delivery system. Our internal Case Management team ensures that the member receives an intake assessment appointment at the county delivery system and is connected with a provider.

In some cases, some federally qualified health centers (FQHCs) or integrated behavioral and physical health provider groups may fill out the transition of care form to send directly to the MHP delivery system.

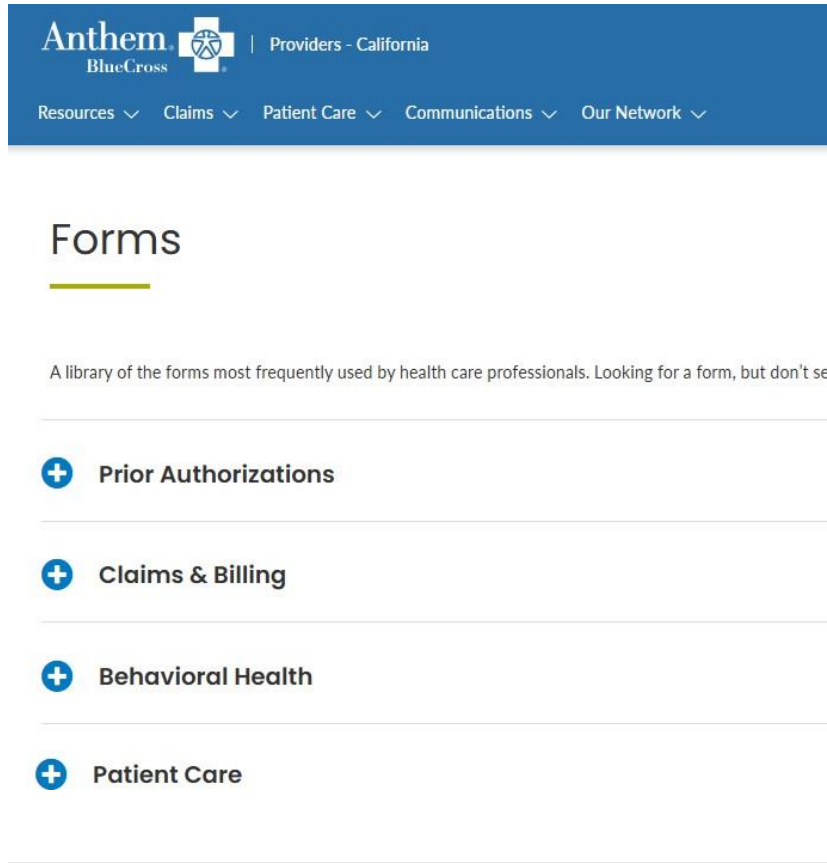
Resources

NSMHS Service Request Form

Provider website: providers.anthem.com/ca

1. Open the *Resources* menu.
2. Select **Forms.**
3. Open the *Behavioral Health* category.

The necessary forms will appear for applied behavioral analysis, psych testing, and out-of-network OP treatment requests.



How to request NSMHS services

Prompts:

- The automated message will ask, “Are you a member or provider?” **Say, “Member.”**
- It will prompt you to enter the member ID number. **Enter the ID number or press 0 three times.**
- The main menu recording will begin. **Press 4** for mental health and substance abuse.

This will connect you to the behavioral health intake team. **Let the team know which type of service you are seeking,** and they will give you a provider list:

1. Psychotherapy
2. Psychiatry
3. ABA (applied behavior analysis; for autism treatment)
4. Psychological or neuropsychological testing

Phone

Behavioral health intake team: **800-407-4627**

Our *Care Management Referral Form*

Our Behavioral Health Case Management (BHCM) team requires member or guardian consent/interest.

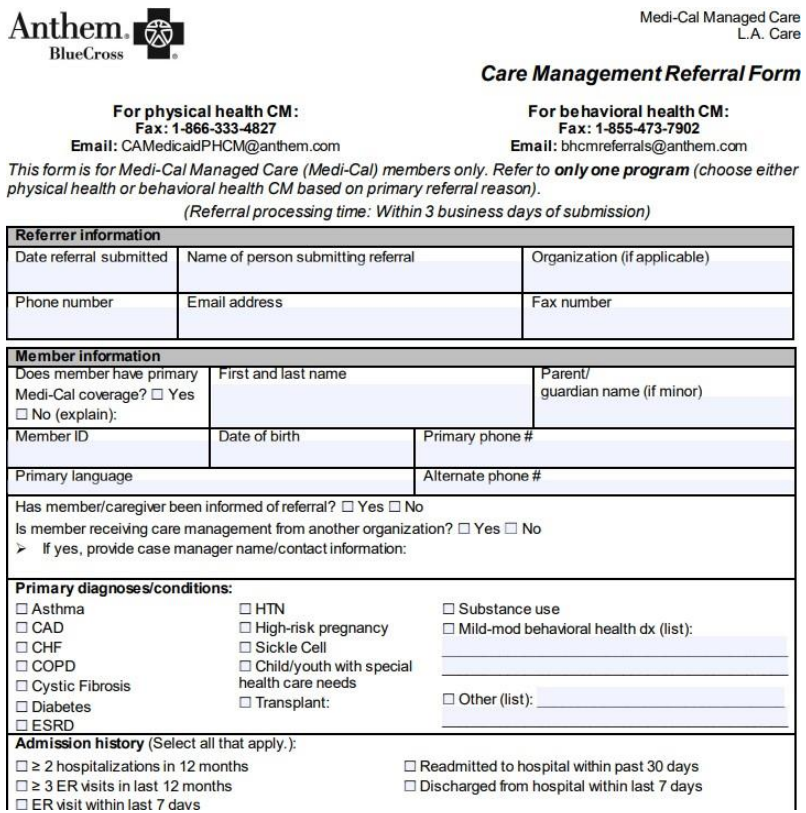
BHCM can assist with coordination with physical health providers, reducing barriers to attendance/compliance, providing community resources.

Referrals are made between the MHP/DMC-ODS and MCPs as needed. Physician groups on the primary care side may also refer members to BHCM.

The referral form may also be used for medical/physical health case management. Refer to the form itself for a complete list.

Provider website: providers.anthem.com/ca

1. Open the *Resources* menu.
2. Select **Forms.**
3. Open the *Patient Care* category.
4. The form is shown as *Case Management Referral Form.*



Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Care Management Referral Form

For physical health CM:
Fax: 1-866-333-4827
Email: CAMedicaidPHCM@anthem.com

For behavioral health CM:
Fax: 1-855-473-7902
Email: bhcmreferrals@anthem.com

*This form is for Medi-Cal Managed Care (Medi-Cal) members only. Refer to **only one program** (choose either physical health or behavioral health CM based on primary referral reason).*

(Referral processing time: Within 3 business days of submission)

Referrer information

Date referral submitted	Name of person submitting referral	Organization (if applicable)
Phone number	Email address	Fax number

Member information

Does member have primary Medi-Cal coverage? ☐ Yes ☐ No (explain):	First and last name	Parent/ guardian name (if minor)
Member ID	Date of birth	Primary phone #
Primary language		Alternate phone #

Has member/caregiver been informed of referral? ☐ Yes ☐ No

Is member receiving care management from another organization? ☐ Yes ☐ No

- If yes, provide case manager name/contact information:

Primary diagnoses/conditions:

☐ Asthma	☐ HTN	☐ Substance use
☐ CAD	☐ High-risk pregnancy	☐ Mild-mod behavioral health dx (list):
☐ CHF	☐ Sickle Cell	
☐ COPD	☐ Child/youth with special health care needs	
☐ Cystic Fibrosis		☐ Other (list):
☐ Diabetes	☐ Transplant:	
☐ ESRD		

Admission history (Select all that apply.):

☐ ≥ 2 hospitalizations in 12 months	☐ Readmitted to hospital within past 30 days
☐ ≥ 3 ER visits in last 12 months	☐ Discharged from hospital within last 7 days
☐ ER visit within last 7 days	

Transportation benefits

Nonemergency medical transportation (NEMT) levels of service:

- Wheelchair van
- Stretcher/gurney van
- Ambulance (BLS, ALS, SCT|CCT)
- Air transport

An authorized PCS form is required.

Nonmedical transportation (NMT) levels of service:

- Mileage reimbursement
- Mass transit, paratransit services
- Ambulatory (sedan, taxi)

A PCS form is sent, but signature is not required.

Hospital discharges or hospital-to-hospital transports
A PCS form is not required.

Reservation hours
Monday to Friday, 7 a.m. to 7 p.m. PT

Advance notice requirements:

- Mass transit/para transit: five business days
- All other transports: five business days

Advance notice is not required for members who need to seek medical attention for the following urgent appointments and treatment types:

- Urgent trips that may take up to four hours to complete
- Dialysis, chemotherapy, radiation therapy, urgent care, wound care, discharges

How members request transportation

Preapproval can be obtained by calling **800-407-4627** or **888-285-7801** Monday to Friday, 7 a.m. to 7 p.m. PT.

Once you have approval, request transportation by calling at least five business days before your appointment: **877-931-4755**

To confirm the estimated time of a ride, to modify an existing reservation, or to file a complaint:

- Where's My Ride: **877-931-4756**
- Bilingual services are available

With Anthem, you don't have to worry about a ride to your next important appointment

We know finding a ride to healthcare appointments, housing, and food services can sometimes be hard. Anthem offers no-cost transportation to help you get the care you need.

- Arrange a ride to medical, same-day urgent care, dental, behavioral health, and substance use disorder appointments – or to pick up prescriptions and medical supplies at the pharmacy.
- Members with food insecurity needs can arrange rides to grocery stores, farmers markets, food banks, and food pantries to pick up food.

1. **Call Anthem transportation reservations toll free at 877-931-4755** at least five business days before your appointment, not including the day you call, weekends or holidays.
2. **Give your member ID number** listed on your member ID card.
3. **If it is your first time calling,** give your primary care provider (PCP)'s name, address, phone and fax numbers.

Transportation to housing and homeless services appointments must be arranged by your Anthem Care Coordinator/Housing Specialist.

Request approval by calling the Customer Care Center Monday to Friday, 7 a.m. to 7 p.m. toll free at **800-407-4627 (TTY 711)**, or **888-285-7801 (TTY 711)** for members in Los Angeles. Once you have approval, follow instructions on the left for calling Anthem transportation reservations.

Anthem points of contact

Points of contact for Anthem			
Where to send	**Email**	**Phone**	**Fax**
Behavioral health intake	N/A	**800-407-4627**	N/A
County mental health plan	N/A	County MHP Contact	N/A
Send TOC	bhcmreferrals@anthem.com	N/A	**855-473-7902**
CalAIM referrals/ECM	CalAIMReferrals@anthem.com	**833-884-0385** (voicemail)	**844-429-9626**

More resources

Downloadable transition of care form (to be completed by our providers):
dhcs.ca.gov/Documents/DHCS-8765-B.pdf

Downloadable adult screening tool form:
dhcs.ca.gov/Documents/DHCS-8765-A.pdf

Downloadable youth screening tool form:
dhcs.ca.gov/Documents/DHCS-8765-C.pdf

DHCS screening and transition of care tools FAQ:
dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-FAQ.aspx

No Wrong Door for Mental Health Services policy (*APL 22-005*)
dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-005.pdf

Adult and youth screening and transition of care tools for Program Ref CD 1:MCMC mental health services (*APL 22-028*):
dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-028.pdf

Thank you