Anthem Centers of Medical Excellence ("CME")
Transplant Network

CONTRACT OPERATIONS MANUAL
for

TRANSPLANT PROGRAM

A supplemental document to the
Anthem Blue Cross Manual

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ANTHEM CENTERS OF MEDICAL EXCELLENCE
TRANSPLANT CONTRACT OPERATIONS MANUAL

SECTION I
Scope

Unless otherwise expressly indicated in this Operations Manual, all terms used shall have the meaning in the Stand Alone Agreement or Transplant Attachment to the Anthem Blue Cross Hospital Agreement.

The Anthem CME for transplant consists of a network of approved providers and facilities (the "Network") for the following transplant procedures: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas. Individual transplant procedures (i.e. heart, lung or combination heart/lung) are referred to in this Manual as a "Program".
The following list of Anthem Blue Cross products will have access to the Network:
The following list of Anthem products will have access to the Network:

- HMO (includes group HMO and POS products such as: HMO Program, POS Program, Select HMO)
- PPO (includes PPO, EPO and CDHP products such as: PPO Program, Select PPO)
- Indemnity/Traditional/Standard (includes products such as: Traditional)
- Exchange Products
- Government Programs: Medicare Advantage and Medicaid (Other includes products such as Senior Select)

All Anthem Blue Cross Covered Individuals, including local, national and Affiliates, have Network access under the terms of the Stand Alone Transplant Agreement or Transplant Attachment to the Hospital Agreement between you and Anthem Blue Cross, attached hereto and incorporated herein.
Please refer to your contract for specific information to product type and exceptions.

SECTION II
QUALITY OVERSIGHT OF THE ANTHEM CME NETWORK

The Anthem CME transplant certification procedures are designed to ensure Covered Individuals, that all Network transplant centers meet Company established clinical criteria and levels of service. Participating transplant centers are selected based on their ability to meet defined clinical criteria that are unique for each transplant type.

To Begin the Certification Process

To initiate the transplant certification process for programs not currently in the Network, prospective applicants should contact their respective Anthem Blue Cross Contract Manager and express your interest. The Anthem Blue Cross Contract Manager will notify the Anthem CME Quality Oversight Department to begin the certification process.

Initial Application and Re-certification

Each prospective transplant center is evaluated independently against established criteria via a Request for Information (RFI) survey. Upon written request, prospective solid organ transplant centers, will submit data using the current online version of the United Network for Organ Sharing (UNOS) Standardized RFI forms. Access to the secure data entry site can be obtained by contacting UNOS. Prospective bone marrow/stem cell centers will submit data using the current American Society for Transplantation and Cellular Therapy (ASTCT) Standardized RFI forms which can be accessed at www.astct.org.

Quality Review Process

The Anthem CME quality review process for participation in the transplant network will include evaluation of selection criteria that encompass, but are not limited to, the following:

Solid Organ Transplant Programs	Bone and Marrow Transplant Programs
1. Volume (by transplant type);	1. Volume (by transplant type);
2. 1-month, 1-year and 3-year patient and graft survival;	2. 100-day and 1-year patient survival;
3. Transplant rate;	3. Percent follow-up;
4. Mortality rate while on the waitlist rate;	4. Transplant team composition, stability;
5. Percent follow up;	5. FACT Accreditation;
6. UNOS Certification	6. CIBMTR data submission

SECTION II
QUALITY OVERSIGHT OF THE ANTHEM CME NETWORK
Continued

Each program is reviewed by the Company's National Transplant Quality Review Committee (NTQRC). The NTQRC is comprised of transplant experts from across the country. There are two committees: one for solid organ transplants and one for blood and marrow transplants. No less than annually, the certification criteria and benchmarks are reviewed and approved by each committee.

Annual re-certification and on-going monitoring of outcomes data assures transplant programs continue to meet applicable Network participation requirements.

Appeal Process

Health care facilities or programs that are not accepted for participation in the network or which are terminated from the Network will be provided the reconsideration or appeal process described in the Anthem Hospital Provider Manual.

Health care facilities or programs that are terminated from the Network will be provided the reconsideration or appeal process described below:

Anthem CME will provide a one-level reconsideration process for currently designated health care facilities or programs that are terminated from the Anthem Centers of Medical Excellence Transplant Network if an appeal is submitted in writing to the Anthem Centers of Medical Excellence Quality Program Manager at the address listed below within thirty days of the date of receipt of the termination letter. The program's written appeal must include the reason why the facility or program should be reconsidered and any corrected/completed data or supporting documentation related to the reason for the appeal. The written appeal information will be reviewed by the National Transplant Quality Review Committee (NTQRC) at its first scheduled meeting following receipt of the appeal and the program will be notified of the appeal review determination via electronic mail and/or UPS mail delivery. The appeal determination is final.

Send Appeal Letter to:
Anthem CME Program Manager
3350 Peachtree Rd. NE
GAG006-0005
Atlanta, GA. 30326

Provider Responsibility

As a participation provider in the Anthem CME transplant network, each center agrees to immediately report major changes in its team or program structures, its federal rating status (such as loss of Medicare certifications) or any event that could result in failure to satisfy the criteria for participation in the network. All health care professionals are required to refer patients to an Anthem approved facility, unless there is a medical reason for referring the patient to a non-approved transplant facility.

SECTION III
TRANSPLANT CARE MANAGEMENT PROGRAM

The procedures outlined below must be followed for each transplant in order to determine Medical Necessity

To Initiate the Member's Transplant Pre - Authorization Review Call:
Phone Number: 1-888-574-7215
Fax*:* 866-255-2471

To Contact the Member's Transplant Case Manager Call:
Phone Number: 1-888-574-7215
Fax*:* 866-255-2471

Identification

Cases are identified to the Case Management Program primarily through referrals from our other medical management programs, the pre-service certification/concurrent review process or from other referral sources such as family, physician, hospital personnel and Company representatives. Cases that meet certain criteria are referred to a transplant case manager for proactive intervention when appropriate.

Non-transplant pre-certification

Please refer to the Anthem Blue Cross Hospital Agreement Provider Manual.
[Please call Customer Service using the phone number listed on the back of the Covered Individual's insurance card for pre-certification requirements for non-transplant services.]

Transplant Review Process

Pre-transplant or Pre-admission [Prior Authorization] Review Process for Transplant. The transplant provider must submit to Anthem a request for transplant authorization and the Covered Individual's clinical records to support this request. Anthem will conduct a review to determine whether a scheduled admission, transplant or transplant services are Medically Necessary. Such review is required for all non-emergent admissions and transplants.

Pre-service Review. For all Covered Individual specific transplant information, please contact the Anthem Transplant team at the numbers above to start the review process as soon as the member is identified for a possible transplant. Pre-service review determines whether the scheduled outpatient and/or ambulatory procedures are Medically Necessary. Services that may be subject to pre-service review include, but are not limited to, the following:

- Pre-transplant evaluation and work-ups
- Donor search and HLA testing (when applicable)
- Marrow/stem cell harvesting collection, modification and/or storage (when applicable)
- Other pre-transplant and post-transplant services provided to the Covered Individual outside of the Global Case Rate Period and/or rendered on an outpatient bases.

Medical Necessity Review Process. The transplant case manager reviews and determines the appropriateness of the diagnosis, the type of transplant requested the referral for transplant, and the Covered Individual's eligibility. After the initial review of the submitted medical records which include the transplant evaluation results, the transplant case manager contacts the CME facility if additional information is required to authorize the requested procedure. Once medical necessity is established, authorization letters are sent to the transplant physician, CME facility and the member. When admission for transplant occurs, the COE facility contacts the assigned transplant case manager for inpatient review, discharge planning and ongoing case management.

SECTION III
TRANSPLANT CARE MANAGEMENT PROGRAM
Continued

Re-certification. For Covered Individual's on a transplant waitlist, regular and ongoing updates and reviews are performed on a case-by-case basis with the COE facility, and will take place no less than once a year. Benefits, eligibility and confirmation that transplant is still part of the treatment plan, will be checked and verified at these intervals. A written confirmation of the updated authorization will be sent via the U.S. mail.

Concurrent Review. Determines whether a continued inpatient stay is Medically Necessary. Such reviews are required for all Covered Individuals during a hospital stay for the actual transplant procedure

Retrospective Review. When pre-certification was not performed prior to the transplant evaluation or the transplant procedure, a thorough review will be done by the transplant case manager to determine if services were Medically Necessary. (Some penalties may apply. Call customer service for more information regarding penalties.)

Member Appeal Process.
Please refer to the appeal process described in the Anthem Blue Cross Hospital Provider Manual.

ATTACHMENT Form A1
TRANSPLANT SERVICES NOTIFICATION FORM

- **Use the tab key to go from field to field**
- **Remember to print and sign this form**

FEP Member ☐ State of Residence _____ Non FEP Member ☐

Referring Anthem Plan

Patient Name | Patient ID #
Date of Birth

Group Name / ID Number | Subscriber Name / ID Number

Primary Insurance Carrier Name | Secondary Insurance Carrier Name

TRANSPLANT TYPE: (please check all that apply)

BONE MARROW/STEM CELL **Patient Diagnosis:** _____

Type: Autologous ☐ Allogeneic ☐ "Mini" Allogeneic ☐ Tandem: #1 ☐ Tandem: #2 ☐

Cell Source: Bone Marrow ☐ Peripheral Blood Stem Cell ☐ Cord Blood ☐

Donor (If Allogeneic): Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐

SOLID ORGAN **Patient Diagnosis:** _____

Organ Type: _____ Initial Transplant ☐ Re-transplant ☐ **Donor:** Cadaveric ☐ Living Donor ☐

Transplant Hospital Name | Transplant Hospital Address

This patient meets the Medical Necessity guidelines of _____ (name of Anthem Plan) for the above noted transplant, for included Transplant Service. All eligible Transplant Services and Global/Outlier Rates are listed in the Centers of Medical Excellence Hospital Participation Agreement.

Contact: _____ at _____ for precertification and to verify continued eligibility for medical benefits prior to beginning CME Transplant Services.

Authorized Plan Representative Signature | Title
Expiration Date

Print Name | Area Code + Phone Number
Fax Number

Contact: _____ at _____ For Case Management Services

Hospital: Submit bundled, GLOBAL CLAIM (including the CME Attachment C or D), and a copy of this CME Attachment A1 – Transplant Services Notification Form to:

Name | Address
Phone Number

ATTACHMENT Form A2
HOSPITAL NOTIFICATION OF TRANSPLANT ADMISSION FORM

(Please reconfirm this Plan claim contact information prior to submitting bundled global claim. Hospital is to collect any applicable coinsurance, deductibles, and co-payments.)

Plan: Provide any additional information or special instructions below (i.e., LTM, COB, deductibles, co-payments, COB for FEP, etc.):

Date _____ FEP Member ☐ Non FEP Member ☐

Non FEP Member
To: Transplant Claim Unit Fax #: 866-255-2471
Phone #: 1-888-574-7215

FEP Member
To: FEP Transplant Unit outside of California Fax #: 866-255-2471
Phone #:1-888-574-7215

From:

Name: _____ Institution: _____

Phone#: _____ Fax #:_____

_____

Patient Name Patient ID # Date of Birth

Referring Blue Cross Plan (or FEP Servicing Plan)

NOTE: Please complete a separate Hospital Notification of Transplant Admission Form for each Transplant.

Solid Organ Transplant

Solid Organ Type: _____ Diagnosis: _____

Initial Transplant ☐ Re-transplant ☐ Cadaveric ☐ Living Donor ☐
Inpatient Admission Date: _____ Inpatient Transplant Date _____
Anthem CME Dates: _____ to _____

Bone Marrow / Stem Cell Transplant

Diagnosis: _____
Check all that apply:
Autologous ☐ Allogeneic ☐ Mini Allogeneic ☐ Tandem #1 ☐ Tandem # 2 ☐
Bone Marrow ☐ Peripheral Stem Cell ☐ Cord Blood ☐
Related ☐ Unrelated☐ Matched ☐ Mismatched ☐

Mobilization Therapy Date(s): Inpatient _____ Outpatient _____
Marrow/Stem Cell Harvesting Date(s): Inpatient_____ Outpatient _____
Marrow Ablative Therapy Date(s): Inpatient _____ Outpatient _____
Reinfusion/Transplant Date(s): Inpatient _____ Outpatient _____
Anthem CME Dates: _____ to _____

ATTACHMENT FORM B
PATIENT DISCHARGE FORM CARE NOTIFICATION FORM

Date: _____ FEP Member ↑ Non FEP Member ↑

Patient Name: _____ ID#: _____

Referring Plan (or FEP Servicing Plan): _____

Date of Transplant: _____ Type of Transplant: _____

Anthem CME Dates: _____ to _____

Institution: _____ Date of Discharge: _____

Hospital:	**Referring Plan (or FEP Servicing Plan)**
_____ (Signature)	_____ (Signature)
_____ (Print Name)	_____ (Print Name)
_____ (Title)	_____ (Title)
_____ (Date)	_____ (Date)

After Completion of Form: Fax one copy to the Referring or FEP Servicing Plan's Transplant Coordinator. Refer to the Referring and Servicing Contact List in the Procedure Manual. Keep one copy for your records.

SECTION IV
ANTHEM CME TRANSPLANT CELL DESCRIPTIONS

Cell 1 includes **evaluation** and all transplant services that are Covered Transplant services required to assess and evaluate the Covered Individual for acceptance to the transplant program. Cell 1 ends with the acceptance and listing on UNOS for solid organ recipient or the non-acceptance of a Covered Individual into the transplant program. For bone marrow/stem cell transplants, Cell 1 ends with the acceptance or non-acceptance of the Covered Individual into the transplant program

Cell 2 includes **pre-transplant care** and all transplant services that are Covered Transplant Services provided to a Covered Individual following acceptance into a Hospital transplant program or Covered Individual's listing with UNOS, until one day prior to the Covered Transplant Procedure. Cell 2 charges related to pre-transplant care end one day prior to the Covered Transplant Procedure. For solid organ transplants this means the end date is two days prior to the Covered Transplant Procedure and for bone marrow/stem cell transplants, the end date is two days prior to initiation of the preparative regimen for autologous and for allogeneic transplants that are Covered Transplant Procedures.

Cell 3 includes the **Covered Transplant Procedure** provided to a Covered Individual. For solid organs the Covered Transplant Procedure begins the day prior to the transplant or for bone marrow begins the day prior to high dose chemotherapy or preparative regimen and ends at the end of the global case rate period or if the covered individual is still inpatient at the end of the global case rate period on the date of discharge from the inpatient stay. If days for inpatient admission for the solid organ or bone marrow transplant exceed the Global Case Rate Period for Transplant, the reimbursement will revert to the Outlier Per Diem Rate for Transplant for all days outside of the Global Case Rate Period, until the date of discharge from inpatient stay.

Cell 4 follow up care includes all Covered Transplant Services provided to a Covered Individual during the six (6) months following the end of Cell 3 for solid organ transplants and fifty (50) days following the end of Cell 3 for a bone marrow/stem cell transplant.

Covered Transplant Services Inclusions for the Four Transplant Cells (use only if this information does not appear in the attachment to your contract) For the purposes of this agreement only Cell 3 is applicable. Cells 1, 2 and 4 will be covered under the terms of the Anthem Local Agreement.

Cell 1: All Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 1 Case Rate. . Covered Transplant Services include the transplant-related health care services and supplies that are provided by Hospital, Group and its Physicians, or other health care professionals who are either employees of Hospital or are subcontracted by Hospital to provide certain services to Covered Individuals; and are provided under the supervision of Hospital and/or the Medical Group and Physicians.

1. Diagnostic testing, including without limitation, evaluation services, HLA typing, and diagnostic testing to determine eligibility or disease stage (if applicable).
2. Donor services, including donor identification, living donor health care services and supplies relating to donation, bone marrow registry charges, Billed Charges, donor search and identification (if applicable).

Cell 2: All Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 2 Case Rate.

Cell 2 includes pre-transplant care and all transplant services that are Covered Transplant Services provided to a Covered Individual following acceptance into a Hospital transplant program or Covered Individual's listing with UNOS, until one day prior to the Covered

SECTION IV
ANTHEM CME TRANSPLANT CELL DESCRIPTIONS
Continued

Transplant Procedure. Cell 2 charges related to pre-transplant care end one day prior to the Covered Transplant Procedure. For solid organ transplants this means the end date is two days prior to the Covered Transplant Procedure and for bone marrow/stem cell transplants, the end date is two days prior to initiation of the preparative regimen for autologous and for allogeneic transplants that are Covered Transplant Procedures.

Cell 3 Inclusions: All Covered Transplant Procedures, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 3 Global Case Rate for Transplant and will not be unbundled and billed to a Covered Individual.

1. Anesthesiology services and supplies.
2. Bone marrow/peripheral blood stem cell (or cord blood) mobilization and harvesting related services (including preparation, transportation, storage and administration) and complications, regardless of when these services occur before transplant (if applicable)
3. Living donor is considered to be a person who donates an organ, part of a solid organ, kidney, liver, lung or bone marrow/stem cells while alive to another person. Covered Services for living donor donation would include Health Services and Medical Services for the donor for up to 30 days after the date of donation.
4. Inpatient rehabilitation services and supplies when Covered Individual is transferred to an inpatient rehabilitation unit post-transplant. Days do not count toward the Global Case Rate Period for Transplant.
5. Inpatient services provided during Cell 3 – all medically necessary services are included in the Transplant Rate, including dialysis (if applicable), room, board and supplies, and pharmaceutical agents and supplies. Nothing is excluded.
6. Organ procurement and transport, including procurement and transport that occurs outside of Facility's service area for all solid organ transplants.
7. Outpatient drugs, supplies and biological agents that are pre-transplant, treatment specific for preparing Covered Individual or Donor for transplant procedure.
8. Outpatient drugs, supplies and biological agents that are given to Covered Individual during the transplant process.
9. Outpatient services provided in Cell 3 – all services are included, including rehabilitation services and supplies, biopsies and laboratory.
10. Preparative regimen for bone marrow, cord blood or stem cell transplant, including chemotherapy, radiotherapy or chemo-radiotherapy (if applicable).
11. Donor leukocyte/lymphocyte infusion post-transplant for boosting engraftment of bone marrow/stem cells if provided while Covered Individual is in Cell 3

Cell 4: Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 4 Global Case Rate Period.

1. Includes all outpatient transplant-related follow-up care for the recipient.
2. Medically Necessary inpatient services.
3. Ancillary services (i.e. home health care services and supplies) provided by Hospital Medical Group or subcontracted providers.
4. Outpatient pharmacy and laboratory are excluded.

Covered Transplant Services Exclusion: the services below delivered during the Global Case Rate Period for Transplant are excluded from the Global Case Rate for Transplant. Excluded Covered Transplant Services will be reimbursed according to the terms of the Anthem Facility, Professional or Ancillary Agreements with Providers.

SECTION IV
ANTHEM CME TRANSPLANT CELL DESCRIPTIONS
Continued

1. Pre Transplant Services prior to the start of the Global Transplant Period except for bone marrow harvest, storage and mobilization services which are included in the Cell 3 Case Rate.
2. Post Transplant Services after the end of the Global Transplant Period and any applicable Outlier Period.

SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES

General Global Billing Guidelines for the Four Transplant Cells

Cell 1 Processing Guidelines (if applicable)
These services will be reimbursed according to the terms of the current Anthem Facility Agreement and the current Anthem Professional Agreement

Cell 2 Processing Guidelines (if applicable)
These services will be reimbursed according to the terms of the current Anthem Facility Agreement and the current Anthem Professional Agreement.

Cell 3 Processing Guidelines
At the end of the Global Case Rate Period for Transplant or Outlier Period for Transplant (if applicable) the HOSPITAL (Provider) will collect all itemized bills (UB 04's and CMS 1500 claim forms) for all inpatient and outpatient-Hospital, Professional, and Ancillary charges included in the Global Case Rate, and outlier rate (if applicable).

All eligible Transplant Services and applicable rates are listed on the compensation schedule. (See Appendix B)

A bundled claim packet should not include claims from the following

- Charges for specifically excluded services noted on the compensation schedule of the Anthem CME Transplant Agreement
- Charges before the Global Case Rate Period for Transplant begins except for Harvest, Storage and Mobilization charges which are included in the Cell 3 Global Case Rate for Transplant
- Charges after the Global Case Rate Period for Transplant and/or after any applicable Outlier Period for Transplant.

Mail the bundled Cell 3 Global Case Rate Period claim packet with the proper Billing Summary Form (See Appendix A) in one envelope to the claim address listed above. Failure to include the Billing Summary
Form may result in delayed correct payment if the Form C for solid organ transplant bundled claims or Form D for bone marrow transplant bundled claims is not included in the bundled packet or the claims bundle is not complete and accurate.

Cell 4 Processing Guidelines (if applicable)
These services will be reimbursed according to the terms of the current Anthem Facility Agreement and the current Anthem Professional Agreement.

Special Billing Instructions

Claim processing:
All claims are processed according to the benefit level in effect at the time the services are rendered.

Living Donor Charges (if applicable):
Claims for living donor charges should be filed with the correct procedure codes and donor diagnosis codes based on the type of service that was rendered to the Covered Individual. Claims should be filed with the recipient's insurance.

SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Non-Anthem (BlueCard) member – Cell 3 Transplant Services:

Transplant services for non-Anthem Covered Individuals utilizing the Blue Card system should be submitted in the same manner as non-transplant claims using the correct address located in the CME manual for your facility. You will not receive an A1 Form from the non-Anthem Plan; however, the case should be set-up and submitted as a global bundle as you would with an Anthem member.

Example

Alpha pre-fix ABP (Blue Cross Blue Shield of North Carolina)

No attachment A1 would be issued but the case should be submitted as a global bundle.

Coordination of Benefits:

Coordination of Benefits for the transplant recipient is the responsibility of the provider on initial contact. Claims will be denied for payment if Anthem Blue Cross and is not the primary insurance coverage and there is not an Explanation of Benefits attached from the primary insurance carrier.

Blue-on-Blue Coverage:

Covered Individuals with coverage through Anthem Blue Cross as primary and secondary payer will have claims processed according to the benefits of each contract. Claims will be filed with the primary coverage and processed based on the benefit guidelines of that Health Benefit Plan. The claim will then be filed with the secondary coverage and processed based on the benefit guidelines of that Health Benefit Plan. Benefits could be processed at different benefit levels based on the contract.

Compensation Schedule

The Compensation Schedule provides information specific to each individual transplant type. The information includes Cell 3 Global Case Rates and the Transplant Services included and excluded during the Global Case Rate Period, which may also include applicable outlier period or pre-transplant period timeframes.

Please contact your Contract Manager for your current Provider Compensation Schedule.

SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Sample Coding (not all inclusive, samples only):
Solid Organ

Transplant Type	CPT Code	ICD-10 Code ***For dates of service on or after 10/01/2015***
Heart	33945 Heart transplant, with or without recipient cardiectomy	02YA0Z0 Transplantation of heart, allogeneic, open approach
Lung	32851 Lung transplant, single; without cardiopulmonary bypass	0BYK0Z0-0BYK0Z1 Transplantation of right lung, open approach [allogeneic, syngeneic]
Liver	47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	0FY00Z0 Transplantation of liver, allogeneic, open approach
Kidney	50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy	0TY00Z0 Transplantation of right kidney, allogeneic, open approach
Pancreas	48554 Transplantation of pancreatic allograft	0FYG0Z0 Transplantation of pancreas, allogeneic, open approach
Organ Acquisition	810-819 (revenue code)	

SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Sample BMT/Stem Cell Coding:

Transplant Type	CPT Code	ICD-10 Code ***For dates of service on or after 10/01/2015***
Autologous	38206 Blood-derived hematopoietic progenitor cell harvesting autologous	
	38232 Bone marrow harvesting for transplantation; autologous	
	38241 Hematopoietic progenitor cell (HPC); autologous transplantation	30230G0-30263G0 Transfusion of autologous hematopoietic stem cells [by site and approach]
Allogeneic	38205 Blood-derived hematopoietic progenitor cell harvesting allogeneic	
	38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	
		30230G1-30263G1 Transfusion of non-autologous bone marrow
		30230Y1-30263Y1 Transfusion of non-autologous hematopoietic stem cells [by site and approach
		30230X1-30263X1 Transfusion of non-autologous cord blood stem cells [by site and approach

SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Donor Services

Services rendered to transplant recipients and donor(s) are reimbursable only if the transplant recipient is enrolled and eligible for Anthem coverage on the date the services are performed.

When billing for services rendered to the transplant donor, providers enter the donor's name on the claim but the recipient's date of birth, sex and Anthem ID number.

Donor ICD 10 and Revenue Codes Bone Marrow/Stem Cell/Cord Blood and Solid Organs

Code	Definition	Submission Note
Bone Marrow/Stem Cell/Cord Blood		
Z52.001	Unspecified Donor, stem cells	NMDP Invoice Submitted Separately from Recipient Claim
Z52.008	Lymphocytes	UB or NMDP Invoice
0819	Other Organ Donor	Stem cell acquisition
Solid Organ		
0811	Living Donor	Line Item on UB on Recipient Transplant Admission Claim
0812	Deceased Donor	Line Item on UB on Recipient Admission Claim
0813	Unknown Donor	Kidney Paired Exchange programs

Z52.000 is the code for whole blood; be sure to reflect the correct modifier when infusion represents BM/Stem Cell or Cord Blood products.

Key fields

UB box 8b – Donor's name

UB box 58 – Insured's name

UB box 59 – Relationship code of 39 or 40

UB box 80 – Remarks noting this is a donor claim submission

HCFA box 19 – Insured's name

Submission Checklist

When checking status to see if the global package has been received or processed, please reach out to customer service at the number on the back of the member's ID card. Considerable training has been done and will continue to be done, so that customer service can handle your inquiries with accuracy and efficiency.

For your convenience, we have compiled a 'checklist' we hope you find useful in ensuring your global packages are prepared with everything required to facilitate a smooth and speedy processing.

- Is the cover sheet present and legible?
- Is it the correct cover sheet for the transplant contract type (BDCT, CME)?
- Completed CME bundled with the cover sheet (Form C or D) included
- Make sure the cover sheet states what type of transplant it is.
- Are all required fields completed, ie type of transplant, global period, figures, etc.
- Is a contact name and phone number and/or email address provided on the cover sheet?
- If Letter of Agreement, is a copy of the LOA included?
- Claims related to transplants where a global fee will be reimbursed should not be filed outside the global package. The cleaner the packages, the faster they can be processed and the faster the payment is released.
- If any claims were sent to Anthem previously and were processed that should have been included in the bundle, these need listed on the cover sheet and deducted from the transplant payment.
- When it is a bone marrow transplant, the provider needs to complete mobilization and harvest dates. In addition, include the High Dose Chemo date.
- Always submit an itemized bill.
- Please make sure the claims attached have correct member id on them
- Please make sure the total charge on coversheet match the total amount with the claims attached.

FORM C
BILLING SUMMARY FORM
SOLID ORGAN TRANSPLANT

Initial Form ☐ Additional Form ☐ Revised Form ☐ Date Revised:_____

Patient Name_____ ID#_____
DOB_____
Transplant Hospital_____
Payment Address:_____
_____
Transplant Type _____ Initial Transplant ☐ Retransplant ☐ Cadaveric ☐ Living Donor ☐

PRE-TRANSPLANT PERIOD DATES/CHARGES

Pre-transplant (Inpatient) Dates:
_____to_____

Inpatient Pre-Transplant Rate if applicable

Hospital Charges:
$_____

Professional Charges:
$_____

Total Billed Charges:
$_____

CASE RATE/AMOUNT DUE

Per Diem Rate $_____ or _____% of Charges

■ Lesser of _____% of Charges

■ Other:
_____
_____

Pre-Transplant Period Amount Due:
$_____

*Total Adjustments (attach itemization and/or claims)
$_____

Pre-transplant Period Total Adjusted Amount Due:
$_____

CASE RATE PERIOD DATES/CHARGES

Case rate period dates
_____ to _____

Transplant Date _____

Inpatient Discharge Date(s)
_____

Readmission Date(s)
_____

Organ Procurement Charges
$ _____
Hospital Charges:
$ _____
Professional Charges:
$ _____
Ancillary Charges:
$ _____
Total Billed Charges:
$_____

CASE RATE/AMOUNT DUE

Applicable Rate:
■ Case Rate Amount
$_____

■ Lesser of _____% of Charges
■ Other:
_____
_____

Case Rate Period Amount Due:
$_____
*Total Adjustments (attach itemization and/or claims)
$_____
Case Rate Period Total Adjusted Amount Due:
$_____

OUTLIER PERIOD DATES/CHARGES

Outlier (Inpatient) Dates:
_____ to _____

Hospital Charges:
$_____

Professional Charges:
$_____

Total Billed Charges:
$_____

CASE RATE/AMOUNT DUE

■ Per Diem Rate $_____ or _____% of Charges

■ Lesser of _____% of Charges

■ Other:
_____
_____

Outlier Period Amount Due:
$_____

*Total Adjustments (attach itemization and/or claims)
$_____

Outlier Period Total Adjusted Amount Due:
$_____

***Hospital**: A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the Case Rate(s) agreement must be attached. *Total adjustments may include e.g., Payor prior payments for services included in the Case Rate(s) agreement.*

*Form Completed by (print name)*_____*Phone*_____*Date*_____
Plan Contact (print

FORM D
BILLING SUMMARY FORM
BONE MARROW/STEM CELL

TRANSPLANT ***Initial Form*** ☐ ***Additional Form*** ☐ ***Revised Form*** ☐ ***Date Revised:*** _____

Patient Name_____ ***ID#***_____
DOB_____
Transplant Hospital_____
Payment Address: _____
Transplant Type/Check all that apply*: Autologous* □ *Allogeneic* □ *"Mini" Allogeneic* □ *Tandem #1* □ *Tandem #2* □ *Peripheral stem cells* □ *Bone Marrow* □ *Cord Blood* □ *Related* □ *Unrelated* □*Matched* □ *Mismatched* □

PRE-TRANSPLANT PERIOD DATES/CHARGES

Pre-transplant (Inpatient) Dates:
_____*to*_____

Inpatient Pre-Transplant Rate if applicable

Hospital Charges:
*$*_____

Professional Charges:
*$*_____

Total Billed Charges:
*$*_____

CASE RATE/AMOUNT DUE

*Per Diem Rate $*_____ *or* _____*% of Charges*

■ *Lesser of* _____*% of Charges*

■ *Other:*
_____
_____

Pre-Transplant Period Amount Due:
*$*_____

**Total Adjustments (attach itemization and/or claims)*
*$*_____

Pre-transplant Period Total Adjusted Amount Due:
*$*_____

MOBILIZATION/HARVESTING DATES/CHARGES

Mobilization Therapy Dates:
*IP*_____
*OP*_____
Mobilization Total Billed Charges:
Hospital
*$*_____
Professional
$ _____
Harvesting Date(s):
*IP*_____
*OP*_____
Harvesting Total Billed Charges: (For Unrelated Donors, i.e., NMDP Charges)
Hospital
*$*_____
Professional
$ _____

CASE RATE DATES/CHARGES

Case Rate Period Dates: _____ *to*_____
Marrow Ablative Therapy (or Preparative Regimen Date(s) :
*IP*_____
OP _____

Transplant Date: _____

Hospital Charges:
$ _____
Professional Charges:
$ _____
Ancillary Charges:
$ _____
Total Billed Charges*:*
*$*_____
(Inc. any applicable mobilization/harvesting charge above)

CASE RATE/AMOUNT DUE

■ *Case Rate Amount*
*$*_____
■ *Lesser of* _____*% of Charges*
■ *Other:*
_____

Case Rate Period Amount Due: (Inc. any applicable mobilization/harvesting charge above)
*$*_____
**Total Adjustments (attach itemization and/or claims)*
*$*_____
Case Rate Period Total Adjusted Amount Due:
*$*_____

OUTLIER PERIOD DATES/CHARGES

Outlier (Inpatient) Dates:
_____ *to* _____

Hospital Charges:
*$*_____

Professional Charges:
*$*_____

Total Billed Charges*:*
*$*_____

CASE RATE/AMOUNT DUE

■ *Per Diem Rate $*_____ *or* _____*% of Charges*

■ *Lesser of* _____*% of Charges*

■ *Other:*
_____
_____

Outlier Period Amount Due:
*$*_____

**Total Adjustments (attach itemization and/or claims)*
*$*_____

Outlier Period Total Adjusted Amount Due:
*$*_____

TOTAL ADJUSTED AMOUNT DUE FROM THE PLAN: $_____

Hospital*: A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the Case Rate(s) agreement must be attached. *Total adjustments may include e.g., Payor prior payments for services included in the Case Rate(s) agreement.*

Form Completed by
*(print name)*_____*Phone*_____*Date*_____
Plan Contact

Anthem CME Transplant Claim Billing Guidelines and Claim Submission Requirements
Please refer to the Anthem Blue Cross Hospital Provider Manual for Billing instructions for non-transplant related claims.

To process your transplant case, please send your CME covered Bundled Hard Copy Transplant Claims and a copy of Form C or D to:

California

Submit all Global Claims except FEP to:
Mabel Lohuiz
CANP01-J004
2000 Corporate Center Drive
Newbury Park, California 91320

FEP Physician Claims

Sandra Holm
FEP Claims Supervisor
Blue Shield of California
4700 Bechelli Lane
Redding, CA 96002

FEP California

Submit FEP Global Claims to:
Cindy Gronert, Operations Expert, Federal Employee Program
5250 South Virginia Street, Reno, Nevada 89502
Office 775-448-4288
Fax 775-448-4281
Mailstop: NV0101-0115
cindy.gronert@anthem.com

Colorado, Nevada

Submit all Global Claims except FEP to:
Mabel Lohuiz
CANP01-J004
2000 Corporate Center Drive
Newbury Park, California 91320

FEP Colorado, Nevada

Submit FEP Global Claims to:

Mallory Hernandez
Anthem Blue Cross and Blue Shield
220 Virginia Ave
Mail Stop IN0204-A568
Indianapolis, IN 46204
317.287.2169
Fax: 317.287.2324
E-mail: Mallory.Hernandez@anthem.com

Connecticut, Maine, New Hampshire

Submit all Global Claims except FEP to:

Lauren Heltke
Hospital Claims
108 Leigus Road
Wallingford, CT. 06492
(203) 677-8420
Email: lauren.heltke@anthem.com

FEP Connecticut, Maine, New Hampshire

Submit FEP Global Claims to:

Justin Keyser
Anthem Blue Cross and Blue Shield
602 S. Jefferson Street
Roanoke, VA 24011
540-853-5177
Fax: 540.853. 5133
E-mail: Justin.keyser@anthem.com

Georgia

Submit all Global Claims including FEP to:

Lacy Long
Blue Cross and Blue Shield of Georgia
6087 Technology Parkway
Mail Drop: GA082E-0003
Midland, GA 31820
706-985-2347
E-mail: Lacy.Long@Anthem.com

SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Indiana, Kentucky, Ohio, Missouri, Wisconsin

Submit all Global Claims except FEP to:
Fran McMahon
Anthem Blue Cross and Blue Shield
4241 Irwin Simpson Rd
Transplant Unit - Mail Stop OH0103-A700
Mason, OH 45040
Fax: 513.336.5508
E-mail: frances.mcmahon@anthem.com

FEP Missouri HMO

Submit FEP Global Claims to:
Fran McMahon
Anthem Blue Cross and Blue Shield
4241 Irwin Simpson Rd
Transplant Unit - Mail Stop OH0103-A700
Mason, OH 45040
Fax: 513.336.5508
E-mail: frances.mcmahon@anthem.com

FEP Indiana (all claims), Kentucky (all claims), Ohio (all claims), Wisconsin (all claims), Missouri FEP PPO

Submit FEP Global Claims to:
Danielle Robbins
Anthem Blue Cross and Blue Shield
220 Virginia Ave
Indianapolis, IN 46204
Mail Loc: IN0204-A568
317.287.2145
Fax: 317.287.2331
E-mail: Danielle.robbins@anthem.com

New York (Empire)

National Accounts:
Submit all Global Claims to:
Brenda Magsamen
Anthem Blue Cross and Blue Shield
85 Crystal Run Road | Middletown, NY 10940
845.695.3355
E-mail: brenda.magsamen@anthem.com

New York (Empire)

Commercial & NYSSC Accounts:
Submit all Global Claims to:
Terri Osborne
Empire Blue Cross and Blue Shield
11 Corporate Woods Blvd. **Mail Stop NY0R4K-9999**
Albany, NY 12211
518.367.5083
Fax: 518.367.6013
E-Mail: terri.osborne@anthem.com

FEP New York (Empire)

Submit FEP Global Claims to:
Pamela Kinowski
Empire Blue Cross and Blue Shield
11 Corporate Woods Blvd. **Mail Loc: NY0R4Y-0035**
Albany, NY 12211
518.367.5124
Fax: 518.367.6124
E-mail: pamela.kinowski@anthem.com

Virginia

Submit all Global Claims to:
Lacy Long
Blue Cross and Blue Shield of Georgia
6087 Technology Parkway
Mail Drop: GA082E-0003
Midland, GA 31820
706-985-2347
E-mail: Lacy.Long@Anthem.com

FEP Virginia

Submit all FEP Global Claims to:
Lacy Long
Blue Cross and Blue Shield of Georgia
6087 Technology Parkway
Mail Drop: GA082E-0003
Midland, GA 31820
706-985-2347
E-mail: Lacy.Long@Anthem.com

ANTHEM CENTERS OF MEDICAL EXCELLENCE
TRANSPLANT CONTRACT OPERATIONS MANUAL
APPENDIX A
COVERED TRANSPLANT SERVICES COVERED BY THIS AGREEMENT

For: _____

Effective: _____

Transplant Type	Adult	Pediatric
Autologous Bone Marrow/ Stem Cell (Single)		
Tandem Autologous/Autologous Stem Cell		
Sequential Autologous Transplants (3 or 4 Autologous Transplants)		
Allogeneic Related Bone Marrow/Stem Cell		
Allogeneic Unrelated Bone Marrow/ Stem Cell		
Cord Blood (single or multiple units)		
Tandem Autologous/Allogeneic Related Stem Cell Transplant		
Tandem Autologous/Allogeneic Unrelated Stem Cell Transplant		
Tandem Autologous/Cord Blood Transplant		
Tandem Allogeneic Related or Cord Blood/Allogeneic Unrelated or Cord Blood Transplant		
Heart		
Heart-Lung		
Lung (Single)		
Lung (Double)		
Liver – Deceased Donor		
Liver – Living Donor		
Liver Kidney		
Kidney – Deceased Donor		
Kidney – Living Donor		
Kidney-Pancreas (SPK)		
Pancreas after Kidney (PAK)		
Pancreas (PAT)		

C = Covered by this Agreement
NC = Not Covered by this Agreement
ND= Reimbursement terms included in this Agreement but program not designated as COE

NATIONAL PROVIDER IDENTIFIER (NPI):

HOSPITALTAX IDENTIFICATION NUMBER (TIN):

MEDICAL GROUP TAX IDENTIFICATION NUMBER (TIN):

CMS IDENTIFICATION NUMBER :

APPENDIX B

Compensation Schedule

Provider Attach Contract Reimbursement Schedule Here