



**Anthem Centers of Medical Excellence (“CME”)  
Transplant Network**

**CONTRACT OPERATIONS MANUAL  
for  
Transplant Program**

**A supplemental document to the  
Blue Cross Blue Shield of Georgia ( BCBSGa ) and the Blue Cross Blue Shield Healthcare Plan of  
Georgia (BCBSHP) Hospital Provider Manual**

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**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 and Blue Shield 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 and Blue Shield products will have access to the Network: (Plan contract specific)

The following list of BCBSGA/BCBSHP products will have a BCBSGa/BCBSHPs to the Network:

- Blue Choice Healthcare Plan (HMO)
- Blue Choice Option (POS)
- Blue Choice (PPO)

[All BCBSGa/BCBSHP Covered Individuals, including local, national and Affiliates, have Network BCBSGa/BCBSHPs under the terms of the Stand Alone Transplant Agreement or Transplant Attachment to the Hospital Agreement between you and BCBSGa/BCBSHP, attached hereto and incorporated herein. Please refer to your contract for specific Information to product type and exceptions].

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**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 and Blue Shield Sr. Provider Network Manager and express your interest. The Anthem Blue Cross and Blue Shield Sr. Provider Network 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 Blood and Marrow Transplant (ASBMT) Standardized RFI forms which can be accessed at [www.asbmt.org](http://www.asbmt.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**

1. Volume (by transplant type);
2. 1-month, 1-year and 3-year patient and graft survival;
3. Transplant rate;
4. Mortality rate while on the waitlist rate; stability
5. Percent follow up

**Bone and Marrow Transplant Programs**

1. Volume (by transplant type);
2. 100-day and 1-year patient survival
3. Percent follow-up;
4. Transplant team composition,
5. FACT Accreditation
6. CIBMTR data submission

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**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 Georgia (and BCBSGa/BCBSHP) Hospital Provider Manual.

**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.

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**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: 866-694-0724**

**Fax: 888-896-8679**

**[Please call Customer Service using the phone number listed on the back of the Covered Individual's insurance card and request to be transferred to the transplant care management department.]**

**To Contact the Member's Transplant Case Manager Call:**

**Phone: 866-694-0724 option 2 for alpha A-L, option 3 for alpha M-Z and ask for Case Manager extension**

**Fax: 888-896-8679**

**[Please call Customer Service using the phone number listed on the back of the Covered Individual's insurance card and request to be transferred to the Covered Individual's transplant case manager.]**

**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 Section III of the Anthem Blue Cross and Blue Shield 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 customer services and ask for the transplant case manager. 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 COE facility if additional information is required to authorize the requested procedure. Once medical necessity is established, authorization letters are sent to the transplant physician, COE facility and the member.

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**TRANSPLANT CARE MANAGEMENT PROGRAM  
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When admission for transplant occurs, the COE facility contacts the assigned transplant case manager for ongoing case management.

**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 and eligibility 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.)

**Appeal Process**

Please refer to the appeal process described in the Georgia (and BCBSGa/BCBSHP) Hospital Provider Manual.

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**SECTION IV**

**ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES**

**Anthem CME Transplant Claim Billing Guidelines and Claim Submission Requirements**

Please refer to the Georgia (BCBSGa/BCBSHP) Hospital Provider Manual for billing instructions for non-transplant related claims.

**Send Bundled Hard Copy [Cell 3] Transplant Claims to:**

Felicia Boswell  
Manager 1 Customer Care  
GA Local Groups Claims and Adj.  
2357 Warm Springs Rd.  
Columbus, GA 31904-5668  
Mail Loc: GAG 302-001

**Questions Regarding Claim Payment:**

Please refer to the member's identification card or to the section in the Georgia (and BCBSGa/BCBSHP) Hospital Provider Manual on claim payment

**Important:**

Please call customer service or the transplant case manager for specific information regarding the member's transplant benefit as described in the Covered Individual's Health Benefit Plan.

**Description of the Four Transplant Cells**

**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 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 transplant exceed the Global Case Rate Period for Transplant, the reimbursement will revert to the Outlier Per Diem Rate for Transplant until the date of discharge from inpatient stay. For bone marrow/stem cell transplants, the Covered Transplant Procedure begins one day prior to the date of marrow ablative therapy (high dose chemotherapy/radiation) began or one day prior to the preparative regimen for non-meloablative therapy and ends fifty (50) days after the date of Covered Transplant Procedure.

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**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 and will not be unbundled and billed to a Covered Individual. 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 and will not be unbundled and billed to a Covered Individual.

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:** 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, transplantation, storage and administration) and complications, regardless of when these services occur before transplant (if applicable).
3. Living donor health care services and supplies relating to donation, including treatment for donor for up to 6 weeks after the date of donation for donor related complications (if applicable). **Living Donor is defined as a person who donates an organ, kidney, liver, lung, or bone marrow/stem cells while alive to another person.**
4. Home health care services and supplies provided during Cell 3 for an outpatient protocol bone marrow/stem cell transplant (if applicable).
5. Inpatient rehabilitation services and supplies when Covered Individual is transferred to an inpatient rehabilitation unit post-transplant. Days do not count toward the total transplant allowable days.

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6. 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.
7. Organ procurement and transport, including procurement and transplant that occurs outside of Hospital's service area for all solid organ transplants.
8. Outpatient drugs, supplies and biological agents that are pre-transplant, treatment specific for preparing Covered Individual or donor for transplant procedure.
9. Outpatient drugs, supplies and biological agents that are given to Covered Individual during the transplant process.
10. Outpatient services provided in Cell 3 all services are included, including rehabilitation services and supplies, biopsies and laboratory.
11. Preparative regimen for bone marrow, cord blood or stem cell transplant, including chemotherapy, radiotherapy or chemo-radiotherapy (if applicable).
12. Donor leukocyte/lymphocyte infusion post-transplant for boosting engraftment of bone marrow/stem cells if provided while Covered Individual is in Cell 3 (if applicable).

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 and will not be unbundled and billed to a Covered individual.

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 Exclusions for Cell 3**

**Add exclusions per negotiated contract**

**General Global Billing Guidelines for the Four Transplant Cells**

**Cell 1 Processing Guidelines (if applicable)**

Processed in accordance with the Anthem Local Agreement

**Cell 2 Processing Guidelines (if applicable)**

Processed in accordance with the Anthem Local 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 92's and HCFA 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:

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- 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
- 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. Form A should be included with solid organ transplant bundled claims.

**Cell 4 Processing Guidelines (if applicable)**

Processed in accordance with the Anthem Local Agreement

**Exclusions –Applies to any cell with a Global Case Rate**

- Hospital Services and Medical Services incurred prior to the start of the Global Case Rate Period
- Hospital Services and Medical Services incurred after the end of the Global Case Rate Period

**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.

**BlueCard Program-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

**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 Blue Shield 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 and Blue Shield 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

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the Global Case Rate Period, which may also include applicable outlier period or pre-transplant period timeframes.

For your reference the Contract and Compensation Schedule(s) are provided in Appendix B.

**Sample Billing Codes**

**Sample ICD-9 Transplant Related Diagnosis Codes**

V59-V59.9 Donor codes

**Sample CPT Transplant Related Codes**

00580, 00796, 00868 Anesthesia-transplant  
33935, 33945 Heart transplant  
32851-32856 Lung transplant  
33935 Heart/lung transplant

38204-38241 Blood or marrow transplant  
47133-47147 Liver transplant  
48550-48556 Pancreas transplant  
50300-50365, 50547 Kidney transplant

**Sample ICD9 Transplant Related Procedure Codes**

00.91-00.93 Donor codes  
33.5—33.52 Lung transplant  
33.6 Combined Heart-lung transplant  
37.50-37.51 Heart transplant

41.00-44.09 Blood or marrow transplant  
50.40-50.59 Liver transplant  
52.80-52.86 Pancreas transplant  
55.60-55.69 Kidney transplant

**Sample Transplant Revenue Codes**

362 Operating Room Services Organ Transplant-Other than Kidney  
367 Operating Room Services Organ Transplant-Kidney  
810-819 Organ Acquisition

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**COVERED TRANSPLANT SERVICES COVERED BY THIS AGREEMENT**

For: \_\_\_\_\_

Effective: \_\_\_\_\_

<b>Transplant Type</b>	<b>Adult/Pediatric</b>
Autologous Bone Marrow/ Stem Cell (Single)	
Tandem Autologous Stem Cell First Procedure	
Tandem Autologous Stem Cell Second Procedure	
Allogeneic Bone Marrow/ Stem Cell Related	
Allogeneic Bone Marrow/ Stem Cell Unrelated	
Cord Blood	
Tandem Allogeneic First Procedure (Auto/Allo) (Allo/Allo)	
Tandem Allogeneic Second Procedure (Auto/Allo) (Allo/Allo)	
Heart	
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

**PROVIDER ID NUMBER (PIN)** \_\_\_\_\_

**HOSPITAL TAX IDENTIFICATION NUMBER (TIN):** \_\_\_\_\_

**MEDICAL GROUP TAX IDENTIFICATION NUMBER (TIN):** \_\_\_\_\_

Anthem Blue Cross and Blue Shield

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**FORM A HOSPITAL NOTIFICATION FORM**

**FORM B PATIENT DISCHARGE FORM**

**FORM C SOLID ORGAN BILLING SUMMARY FORM**

**FORM D BONE MARROW/STEM CELL**



HOSPITAL NOTIFICATION OF TRANSPLANT ADMISSION FORM

Date \_\_\_\_\_ FEP Member  Non FEP Member

<b>Non FEP Member</b>			
To:	Transplant Claim Unit	Fax #:	513-336-5508
	<b>Insert Plan Specific Information</b>	Phone #:	800-824-0851

<b>FEP Member</b>			
To:	FEP Transplant Unit	Fax #:	317-287-2324
	Anthem Blue Cross Blue Shield		
	1099 North Meridian Suite 1200		
	Indianapolis, IN 46204	Phone #:	317-287-2145

From:

Name: \_\_\_\_\_ Institution: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_  
Patient Name Patient ID # Date of Birth

Referring Blue Cross and Blue Shield 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 \_\_\_\_\_



**FORM B**  
**PATIENT DISCHARGE FORM CARE NOTIFICATION FORM**

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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.



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:
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:
\$ \_\_\_\_\_

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 (print name) \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_



**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, ie, 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 CaseRate(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 name) \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

ANTHEM BLUE CROSS AND BLUE SHIELD  
ANTHEM CENTERS OF MEDICAL EXCELLENCE  
TRANSPLANT CONTRACT OPERATIONS MANUAL

**APPENDIX B**

**Compensation Schedule**

Attach Contract Reimbursement Schedule Here