



## NQTL SELF COMPLIANCE TOOL CONTINUED STAY/CONCURRENT REVIEW

1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply.

Anthem's fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary. The plan document example is attached as Exhibit 1 and details how the concurrent review process works for members. Concurrent Review is defined in the plan documents as: "A utilization review of a service, treatment or admission for a benefit coverage determination that must be done during an ongoing stay in a Facility or course of treatment." Providers are informed of this process in the "Utilization Management" section of the Provider Manual.

This analysis explains when Anthem performs a continued stay/concurrent review and how Anthem's processes, strategies, evidentiary standards and other factors for continued stay/concurrent review comply with the non-quantitative treatment limitation (NQTL) requirements under MHPAEA.

The concurrent review NQTL applies to medical/surgical and mental health/substance use disorder services in the inpatient (in-network, out of network) and outpatient (in-network, out of network) benefit classifications.

Anthem has included some definitions used throughout the analysis:

- **Availity Prior Auth Portal (AVPortal):** Anthem's application on Availity web portal in submission of requests for service. (It is currently available for limited physical health providers by provider state).
- **Continued Stay Review:** Utilization review that is conducted during a covered person's ongoing stay in a facility or course of treatment. Continued stay review includes continuation of services (Urgent Care & Extensions).
- **Interactive Care Reviewer (ICR):** Anthem's application inside the Availity web portal for providers to submit requests. It allows providers to electronically submit utilization review requests to Anthem and track the status of requests.
- **Peer Clinical Reviewer (PCR):** means a physician, nurse practitioner\*, doctoral-level clinical psychologists or certified addiction-medicine specialists, pharmacist, dentist, chiropractor, physical therapist professional, or doctoral-level board-certified behavioral analysts\*\* who:
  - Has education, training or professional experience and a current license or an administrative license; or
  - Is a board-certified consultant.

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use



disorder benefits and medical or surgical benefits:

- a. Member is inpatient or in an ongoing course of treatment.
- b. The provider is requesting that ongoing care be reviewed for medical necessity.
- c. The service is subject to prior authorization.

**Factor Weighting:** All three of the above factors are weighted equally to determine when concurrent review is applied to M/S and MH/SUD services.

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Anthem conducts a continued stay/concurrent review when the treating provider/facility requests that the member's inpatient stay or an ongoing course of outpatient treatment/stay be approved for due to the member's current medical condition. Anthem does not initiate any concurrent reviews for either MH/SUD or M/S services.

**Member is Inpatient or in Ongoing Course of Treatment:** If the member is receiving inpatient care or an ongoing course of treatment, and the previously authorized duration of treatment or number of approved visits/sessions is set to expire, the provider may request additional days of inpatient stay or additional visits/sessions to be authorized. Anthem considers this a continued stay/concurrent review request. The only evidentiary standard used for such factor is the current course of treatment experienced by the member, and the amount of previously authorized treatment.

**Service is Subject to Prior Authorization:** Continued stay/Concurrent Review is often performed on services that pre-service required prior authorization. In the event the days or visits authorized are set to expire, the provider can submit a request for continued stay/concurrent review in order for additional days or visits be authorized. The standards for services requiring prior authorization are separately detailed in the Prior Authorization NQTL comparative analysis.

**Provider Request Ongoing Care to be Reviewed for Medical Necessity:** A provider may request additional services from those previously authorized or submit a request a medical necessity review for continued stay or additional treatment. There is no evidentiary standard used for this as it is completely within the provider discretion.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits?

**Continued Stay Written Process:** The continued stay/concurrent review process commences when an individual member is in an ongoing inpatient stay or receiving a course of outpatient treatment and is approaching the limit of the previously authorized treatment/stay. The provider/facility can submit a request for an extension of treatment previously authorized through the Availity portal (or by phone and



fax). Upon receipt, the information will be first reviewed and entered into the Anthem Care Management System (ACMS), and ultimately reviewed by a member of the clinical team for medical necessity against the respective guideline. The clinician will perform the clinical review and may approve the request if it meets the medical necessity guideline. If it is not clear that the request meets the medical necessity guideline, the clinician will refer the request to the Peer Clinical Reviewer for a decision. Only the Peer Clinical Reviewer may deny a request. The decision is ultimately provided back to the requesting provider/facility.

In some instances, a healthcare professional or non-clinical staff member may perform outreach to the provider/facility after the last approved day and inform them that a request for an extension has not been received and/or to submit the discharge date for the member. If a member is still receiving treatment, the provider/facility will be requested to submit the clinical information supporting the extension. Clinical information submitted will be reviewed by the Peer Clinical Reviewer for an ultimate decision to approve or deny the request. If information is not provided, then the non-clinical staff will document the discharge date as the day after the last approved or the denied decision date in the medical management system.

The process is applied for continued stay/concurrent review of M/S and MH/SUD services.

#### **Continued Stay Operational Data:**

In performing the operational comparative analysis, Anthem annually pulls data from the Anthem Care Management Platform (ACMP). The data includes all continued stay/concurrent reviews performed for M/S and MH/SUD claims. First, Anthem reviews the total amount of claims subject to concurrent review. In general, Anthem will receive more concurrent review requests for M/S services, with the exception of inpatient, out of network. Anthem does not typically receive many outpatient concurrent reviews as they don't typically meet the factors above (e.g., member in ongoing course of treatment/stay). Thus, M/S services are typically subject to concurrent review at a higher rate than MH/SUD. When reviewing the outcomes of the reviews, MH/SUD services are typically approved at a higher rate than M/S services, with some very limited exceptions. The data is reflected in **Exhibit 2**.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes, Anthem applies the same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and M/S benefits. Anthem does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. Furthermore, the comparative analysis reviewing the claims subject to concurrent review demonstrates MH/SUD services are generally approved at a similar or higher rate than M/S services. Therefore, Anthem complies with parity requirements for concurrent review in writing and in operation.

## EXHIBIT 1 STANDARD FULLY INSURED EOC PROVISION

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### Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

### Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis in a Hospital setting but may be approved at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Certain services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

**Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:**

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;

4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

### Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

**Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us with 48 hours of admission, or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay / Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

### Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor (“requesting Provider”) will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	<ul style="list-style-type: none"> <li>The Provider must get Precertification when required</li> </ul>
Out-of-Network / Non-Participating	Member	<ul style="list-style-type: none"> <li>Member must get Precertification when required (Call Member Services).</li> <li>Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.</li> </ul>
BlueCard Provider	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> <li>Member must get Precertification when required. (Call Member Services.)</li> <li>Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.</li> <li>BlueCard Providers must obtain precertification for all Inpatient Admissions.</li> </ul>
<p>Note: For an Emergency Care admissions, precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.</p>		

### **How Decisions are Made**

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions



identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the “Complaints and Appeals” section to see what rights may be available to you.

### **Decision and Notice Requirements**

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

<b>Type of Review</b>	<b>Timeframe Requirement for Decision and Notification</b>
Urgent Pre-service Review	24 hours from the receipt of request
Non-Urgent Pre-service Review	72 hours, or 2 business days, whichever is less from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	1 business day from the receipt of the request
Non-urgent Concurrent Continued Stay Review for ongoing outpatient treatment	1 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.



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**EXHIBIT 2**  
**CONCURRENT REVIEW**  
**GEORGIA – SELF FUNDED GROUP (ASO)–LOCAL COMMERCIAL**

**Inpatient, In-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	17704	3052	85%
Group MH/SUD	3252	164	95%

**Inpatient, Out-of-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	3305	896	78%
Group MH/SUD	1176	61	95%

**Outpatient, In-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	0	0	N/A
Group MH/SUD	0	0	N/A

**Outpatient, Out-of-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	0	0	N/A
Group MH/SUD	0	0	N/A

Note: Data is for self-funded plans whose plans are headquartered in Georgia without regard to where the members of the plan reside (e.g., group is headquartered in Georgia but members may live in-or-outside of Georgia). Data includes requests for precertification as well (i.e., services that are not on the prior authorization list). It also includes requests to see an out-of-network provider.

Report run on or around February 27, 2023 by Tina Jones, Business Info Developer Consultant, Sr.



## NQTL SELF COMPLIANCE TOOL

### Commercial Products

### Credentialing

1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply.

If a plan that Anthem insures or administers requires the use of a provider network, this document explains how Anthem has developed and applies the credentialing program, which must be successfully satisfied before a provider may participate in the Anthem provider network. Out-of-network and certain in-network providers are not in scope for Anthem's credentialing program. Examples of plans that require the use of a network are Preferred Provider Option (PPO) plans, Point of Service (POS) plan, Health Maintenance Organization (HMO) plans or Exclusive Provider Organization (EPO) plans. HMO and EPO plans require the use of an in-network provider, except in the case of an emergency or if a referral to a non-network provider is approved in advance of the care. PPO and POS plans cover services from both in-network and out-of-network providers, but members will pay more in cost-sharing (i.e., deductible, coinsurance and copayments) if they use an out-of-network provider.

The Credentialing NQTL is applied to any M/S and MH/SUD services rendered by a network provider in-scope for credentialing within the inpatient in-network, outpatient in-network, and emergency benefit classifications.

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits::

The credentialing program ensures in scope network providers are appropriately reviewed for professional competency to protect member safety and quality of services. The factors in developing the program include:

- **Independent Practitioner Status**
- **Professional Competency**

Anthem considers all of the factors equally in determining whether to require a provider to be credentialed. The above factors are included within the National Committee for Quality Assurance (NCQA) credentialing program accreditation requirements. Anthem is accredited by the NCQA for credentialing and follows the NCQA standards unless a state or federal standard applies.

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

- **Independent Practitioner Status:** In determining the providers within the scope of the credentialing program, Anthem considers the practitioner type and the scope of their allowed practice. Anthem has incorporated the NCQA accreditation requirements as the evidentiary standard to



determine whether a provider is subject to credentialing requirements. The standard requires the following to be satisfied:

- Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
- Practitioners who have an independent relationship with Anthem
  - An independent relationship exists when Anthem directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
- Practitioners who are directed to provide care to Anthem members.

Anthem has evaluated provider types meeting this standard and included them within the scope of the credentialing program. In doing so, Anthem reviews the following source materials to determine if the provider type will be subject to credentialing requirements:

- NCQA (the NCQA will exclude certain providers that are facility based among others)
- State provider licensing laws/requirements,
- State Medicaid guidelines, and
- State defined scope of practice requirements (e.g., Board of Medical Licensure).

In the event a provider is not able to practice independently and must provide care under the supervision of another provider, they do not meet the requirements for credentialing. The scope determination is applied uniformly to all MH/SUD and M/S providers.

- **Professional Competency:** Professional competency standards are established to provide a manner to evaluate the qualifications of practitioners and healthcare delivery organizations to determine if they meet minimum competency standards for participation in the network.

Anthem reviews information from multiple sources including the:

- Provider's CAQH or Anthem Application,
- National Practitioner Data Bank (NPDB) reports,
- Credentialing Verification Organization reports (primary source verification of provider's background information),
- Board certification status through Board Certification agencies (indicate board certs [here](#))
- Education Verification through AMA or Provider's indicated professional school,
- State Licensing Board Reports/Orders,
- DEA certificate status, and
- Medicare/Medicaid List of Excluded Entities from federal and/or state regulatory agencies.

The evidentiary standards used in evaluating whether a practitioner meets the participation criteria include:



- Licensure – in reviewing the state licensing board information, is the applicant appropriately licensed?
- Education and Training - Does the provider have the necessary education and training and, depending on the specialty, have the appropriate board certification?
- Accreditation - If the provider is a facility, has it successfully completed the accreditation process by a nationally recognized third-party accreditation entity?
- Criminal – Has the provider been convicted of a felony or serious misdemeanor?
- Malpractice Claims History – Does the provider have a malpractice claims history?
- Sanctions - Is the provider currently or previously subject to federal sanction, debarment, or exclusion from participation in Medicare, Medicaid, or FEHBP?
- DEA Certificate - If necessary, does the provider have a current, valid, unencumbered DEA/CDS registration in the state?
- State Approved - Is the provider approved by New York state to participate in the New York Medicaid program?

In reviewing the above, some of the elements are automatic disqualifiers if not fulfilled (e.g., current sanctions, accreditation, licensure) while others may have some very limited exceptions that can be reviewed if not met (e.g., board certification). For example, all M/S and MH/SUD providers at the MD or DO level, must satisfy the criteria applicable to MDs and DOs. Providers outside of MDs and DOs have participation criteria tailored to their specific type as much of the MD/DO criteria would not be applicable. Nurse Practitioners, Certified Midwives, Licensed Clinical Social Workers, Psychologists, among others, have to satisfy the education and training requirements specific to their profession as all MH/SUD and M/S providers must satisfy education and training requirements to demonstrate professional competency to treat Anthem members.

In general, the criminal history, malpractice claims history, work gaps and others are evaluated to determine if such issue is determined to present a reasonable suspicion of future substandard care. The standard is subjective and based upon the deliberation and judgment of the committee members. These professional competency decisions are evaluated by the Geographic Credentials Committee (GCC). The GCC meets, at a minimum, every 45 days. Determinations to deny an applicant's participation or terminate a Practitioner or HDO from participation in one or more of the Company's programs or provider network(s) require a majority vote of the voting members of the GCC in attendance, the majority of whom are participating providers.

#### **Process Review:**

The attached Credentialing Program Summary describes in more detail Anthem's credentialing requirements that help ensure we have qualified providers in our networks.

Anthem's National Credentials Committee ("NCC") oversees the credentialing process. The NCC establishes the policies and procedures for:



- a. Credentialing, re-credentialing, ongoing monitoring and oversight of network Practitioners<sup>1</sup> and Health Delivery Organizations (“HDO”)<sup>2</sup>;
- b. The delegation of credentialing related activities;
- c. Appeals of adverse credentialing decisions; and
- d. Review of Company clinical staff qualifications and approval for those staff to perform clinical functions on behalf of the Company.

The NCC policies are required to:

- a. Comply with relevant federal law;
- b. Meet standards set by relevant regulatory and accrediting bodies;
- c. Be modified for state specific use to comply with state law where applicable; and
- d. Be reviewed at least annually and revised as necessary.

The NCC is composed of ten to twelve Anthem medical directors (excluding the chair) selected to represent various clinical and business areas of Anthem. It is chaired by an Anthem medical director as designated by the Vice President (VP) responsible for Enterprise Credentialing Policy. The VP responsible for Enterprise Credentialing Policy reports to the Chief Medical Officer. Other representatives of the NCC include:

- At least two medical directors representing Commercial and Medicaid lines of business, respectively, and one medical director representing Medicare line of business;
- At least one medical director representing behavioral health; and
- At least two medical directors who act as chairs/vice-chairs of geographic Credentials Committees.

Policies approved by NCC will govern credentialing of network practitioners and HDOs including, but not limited to scope, criteria, confidentiality, delegation, and appeals. Credentialing Policies established by the NCC will be presented to the GCC for input, review and adoption at least annually.

Anthem has established geographic Credentials Committees (“GCC”) on either a specific state or regional basis.<sup>3</sup> Each GCC is made up of a chair, who is the medical director for the state or a state within the designated region, a vice chair and at least five (but no more than ten) external participating physicians representing multiple medical specialties. In general, the following specialties or practice-types are represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine), surgery, and behavioral health. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the GCC.

The GCC meets, at a minimum, every 45 days. Determinations to deny an applicant’s participation or terminate a Practitioner or HDO from participation in one or more of the Company’s programs or provider network(s) require a majority vote of the voting members of the GCC in attendance, the majority of whom are participating providers.

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<sup>1</sup> A Practitioner is an individual person who is licensed or certified (as applicable) in accordance with all applicable state and federal laws to deliver health care services

<sup>2</sup> An HDO is a facility, institution or entity that is licensed or certified (as applicable), in accordance with all applicable state and/or federal laws, and that provides or delivers health care services

<sup>3</sup> Anthem has 21 GCCs.



MH/SUD and M/S practitioners or HDOs are subject to Anthem's credentialing if they satisfy three requirements (identical to NCQA scope requirements):

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision);
- Practitioners have an independent relationship with the organization; and
- Practitioners provide care to Anthem members.

The scope determination is applied uniformly to all MH/SUD and M/S providers. Providers within the scope of credentialing must complete the entire process to be permitted to join the Anthem network.

If a Practitioner or HDO meets all of the participation criteria for initial or continued participation, then the Credentialing staff will present that provider for approval by the chair or vice chair of the GCC. The participation criteria include the necessary elements to demonstrate professional competency and is tailored to the specific M/S and MH/SUD provider types within scope for credentialing. Narrowly tailored exceptions to certain participation criteria (e.g., board certification requirement) are available for M/S and MH/SUD providers. Practitioners or HDOs who do not meet all of the participation criteria or have other issues that require individual consideration, will be presented to the GCC for an individual review and credentialing determination.

Determinations to deny an applicant's participation or terminate a Practitioner or HDO from participation in one or more of the Company's programs or provider network(s) require a majority vote of the voting members of the GCC in attendance, the majority of who are participating providers.

Additionally, the GCC will review the credentialing program and conformance to the Company's standards of any entity for which delegation of credentialing is being considered and will determine the acceptance or denial of the entity for such delegation.

Practitioners requesting initial participation will be notified of the decision by appropriate Company personnel within ninety (90) days of receipt of a completed application or within 60 days of the GCC decision, whichever is earlier. This notification may occur electronically or via standard mail.

Practitioners can submit an application by visiting [www.anthem.com](http://www.anthem.com), selecting "Providers" then selecting "Credentialing."

A complete application includes:

- Signature and application date
- CAQH status of "Initial Application Complete" or "Reattestation"
- Current license to practice in each state where services are provided
- Education/Training to support requested specialty(ies) (or documentation that provider will complete training within 60 days of application)
- Current Hospital Privilege information
- Current DEA or CDS certificate in each state where services are provided
- Explanations to questions on the application



- Five years' work history, in month/year format
- Current Professional Liability Insurance
- Applicant must also allow a site review within 30 days of our request, if applicable

If a Practitioner or HDO's application is declined or the Practitioner or HDO is terminated during a credentialing review, a letter will be sent and, depending on the circumstances, the Practitioner or HDO may have the right to either (1) submit additional information for reconsideration; or (2) file a formal appeal.

In any case in which the Company delegates any credentialing functions, the delegation will be governed by a mutually agreed upon delegation agreement. The delegation agreement must be in place before delegated activities are performed. The Company oversight entails a process for routine, ongoing reports, and a clearly defined audit program.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:

Anthem's processes, strategies, evidentiary standards and other factors for provider credentialing are comparable for both mental health/substance use disorder providers and medical/surgical providers. Anthem applies its credentialing policies uniformly to all providers. The credentialing process is thoroughly described above and within the Credentialing Program Summary.

The participation criteria is also generated based on NCQA standards, state licensure standards, and Anthem internal considerations, and apply to all M/S and MH/SUD within scope of Anthem's credentialing program. The criteria is defined based on the specific provider level. For example, all M/S and MH/SUD providers at the MD or DO level, must satisfy the criteria applicable to MDs and DOs. Providers outside of MDs and DOs have participation criteria tailored to their specific type as much of the MD/DO criteria would not be applicable.

At least annually, usually in January or February, Anthem conducts an analysis to evaluate and ensure that Anthem is administering its credentialing program according to its policies. This report tracks the reason for denials and terminations and a review is done to ensure the reason for the denial or termination is consistent with policy.

The comparative analysis demonstrating the comparable application of credentialing policy and process is shown below for calendar year 2022, based on the annual report run in January 2023 by a Credentialing Director. There are very few denied/terminated cases for professional competency reasons out of the total cases reviewed.

#### **Initial Denials Summary 2022**

<b>Number of Med/Surg Initial Denial</b>	<b>58</b>
<b>Number of MH/SUD Initial Denial</b>	<b>10</b>



#### Med/Surg Initial Denial Reasons:

License/Board Action	32
Hospital Action	12
Not Board Certified	5
Malpractice	5
Hospital Privileges	2
DEA	2

#### MH/SUD Initial Denial Reasons:

License/Board Action	5
Work History Gap	2
Criminal Conviction	1
Education/Training	1
Not Board Certified	1

### **Recredentialing Terms Summary 2022**

**Number of Med/Surg Recred Terms 59**

**Number of MH/SUD Recred Terms 8**

#### Med/Surg Recred Term Reasons:

License/Board Action	17
Hospital Privileges	17
Not Board Certified	15
Hospital Action	5
Malpractice	3
DEA	2

#### MH/SUD Recred Term Reasons:

License/Board Action	6
Not Board Certified	1
Hospital Action	1

### **Off Cycle Terms Summary 2022**

**Number of Med/Surg Off Cycle Terms 142**

**Number of MH/SUD Off Cycle Terms 27**

#### Med/Surg Off Cycle Term Reasons:

License/Board Action	123
Federal Sanction	7
Criminal Conviction	6
DEA	4
Quality of Care	1
Hospital Action	1

#### MH/SUD Off Cycle Term Reasons:

License/Board Action	25
Federal Sanction	1
DEA	1

Anthem processed 48,762 total initial applications in 2022 and only denied 68 applicants.

### **Turnaround Time for Credentialing**

Anthem has reviewed the credentialing timeframes for those providers being initially credentialed (includes initial applicants and those of former delegated groups). The data provides a comparison of the total number of providers credentialed within a timeframe (completed application to decision) measured in days. The turnaround time report was pulled and compiled on February 28, 2023 from information within the CACTUS database.

### **Mental Health/Substance Use Disorder Providers**



State/Region GCC	0-5 Days	06-10 Days	11-15 Days	16-30 Days	31-40 Days	41-50 Days	51-75 Days	76-100 Days	over 100 Days	Grand Total
CA Cred Committee	1366	1264	396	331	91	18	20	2		3488
CO Cred Committee	384	293	63	61	26	7	6	2	2	844
Empire Cred Committee	765	710	160	136	27	14	7	1		1820
GA Cred Committee	380	251	80	41	5	1	2			760
IA Cred Committee	45	38	119	155	3	2	1			363
IN Cred Committee	406	140	17	24		3				590
KY Cred Committee	193	158	50	53	11	3	9	6	13	496
LA Cred Committee	66	32	57	195	4	2				356
MO Cred Committee	227	153	71	151	62	68	53	18	8	811
NE Cred Committee	714	361	83	73	12	6	3		2	1254
Nebraska Cred Committee	56	42	52	158		1	2	1		312
NJ Cred Committee	27	16	10	67	7	2	1	1		131
NV Cred Committee	216	208	42	45	12	11	4	2	5	545
OH Cred Comm	541	357	130	134	45	22	51	27	8	1315
TN Cred Committee	66	62	40	34					1	203
TX Cred Committee	22	74	195	324	74	15	15	10	5	734
VA Cred Committee	812	479	142	117	58	18	21	6	4	1657
WA Cred Committee	56	75	23	10	2		1		1	168
WI Cred Committee	346	387	141	93	11	9	8	5	10	1010
<b>Grand Total</b>	<b>6688</b>	<b>5100</b>	<b>1871</b>	<b>2202</b>	<b>450</b>	<b>202</b>	<b>204</b>	<b>81</b>	<b>59</b>	<b>16857</b>
	<b>40%</b>	<b>30.3%</b>	<b>11.1%</b>	<b>13%</b>	<b>2.6%</b>	<b>1.2%</b>	<b>1%</b>	<b>0.5%</b>	<b>0.3%</b>	

10 initial applicants were denied resulting in a 0.05% denial rate for initial MH/SUD providers.

### Medical/Surgical Providers

State/Region GCC	0-5 Days	06-10 Days	11-15 Days	16-30 Days	31-40 Days	41-50 Days	51-75 Days	76-100 Days	over 100 Days	Grand Total
CA Cred Committee	563	457	306	442	131	76	76	16	24	2091
CO Cred Committee	260	284	115	93	25	14	13	2	3	809
Empire Cred Committee	1270	1228	347	314	64	41	22	6	7	3299
FL Cred Committee	220	131	141	485	14	11	10	5	1	1018
GA Cred Committee	247	205	94	112	22	8	5	1		694
IA Cred Committee	104	39	144	276			1			564
IN Cred Committee	813	653	159	134	4			1		1764
KY Cred Committee	312	268	92	89	20	5	13	23	52	874
LA Cred Committee	213	113	185	546	11	11	2			1081
MD Cred Committee	117	312	196	179	36	19	64	20	2	945
MO Cred Committee	325	275	141	263	108	103	108	37	45	1405
NE Cred Committee	844	821	465	694	85	66	34	9	59	3077
Nebraska Cred Committee	106	49	70	320	2	2	2	1		552
NJ Cred Committee	245	84	97	673	51	72	85	21		1328
NV Cred Committee	466	588	228	219	52	22	33	5	7	1620
OH Cred Comm	580	569	274	418	121	91	82	48	33	2216
TN Cred Committee	513	666	439	545	6		1	1		2171
TX Cred Committee	122	201	534	981	195	52	53	23	9	2170
VA Cred Committee	752	900	373	397	128	69	58	12	9	2698
WA Cred Committee	205	236	101	53	8	3	3			609



WI Cred Committee	221	290	152	127	47	20	38	5	19	919
WMC Cred Committee				1						1
<b>Grand Total</b>	<b>8498</b>	<b>8369</b>	<b>4653</b>	<b>7361</b>	<b>1130</b>	<b>685</b>	<b>703</b>	<b>236</b>	<b>270</b>	<b>31905</b>
	<b>26.6%</b>	<b>26.2%</b>	<b>14.6%</b>	<b>23.1%</b>	<b>3.5%</b>	<b>2.2%</b>	<b>2.2%</b>	<b>0.75%</b>	<b>0.85%</b>	

58 initial applicants were denied resulting in a 0.18% denial rate for initial M/S providers.

The turnaround time data indicates mental health/substance use disorder providers are not subject to more stringent credentialing requirements than their medical/surgical counterparts. 70% of MH/SUD providers are credentialed within 10 days of receipt of a completed application compared to 53% of M/S providers, while the vast majority of providers overall are credentialed within 30 days.

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. Anthem's processes, strategies, and factors are the same for MH/SUD and M/S providers. The processes are largely dictated by federal law, state law, and accreditation organization requirements (i.e., NCQA), and are focused on ensuring professionally competent practitioners are treating Anthem members. The specific professional competency criteria requirements are developed as applicable to the particular provider specialty within the scope of Anthem's credentialing program as dictated by the NCQA. Exceptions to certain criteria are available to both M/S and MH/SUD providers. Lastly, the operational data demonstrates relatively few providers are denied overall, and it isn't applied in a more restrictive manner to MH/SUD providers. Specifically, a lower overall proportion of MH/SUD providers are denied credentialing, and a higher percentage of MH/SUD providers are credentialed within 10 days of receipt of a completed application. Therefore, Anthem is not applying credentialing requirements more stringently to MH/SUD providers.

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# Credentialing

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## **ANTHEM'S DISCRETION**

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of Anthem's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

### Credentialing Scope

#### **Credentialing requirements apply to the following:**

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Anthem
  - An independent relationship exists when Anthem directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Anthem's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
  - That are part of Anthem's primary Network and include Anthem Members who reside in the rental network area.
  - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Anthem credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan

- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Anthem credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes
  - Ambulatory Detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Use Disorder
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Use Disorder Clinics
  - Partial Hospitalization – Mental Health and/or Substance Use Disorder
  - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)  
End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission)
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

## **CREDENTIALS COMMITTEE**

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Anthem's networks or plan programs is conducted by a peer review body, known as Anthem's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Anthem affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Anthem's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

## **NONDISCRIMINATION POLICY**

Anthem will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Anthem will take appropriate action to track and eliminate those practices.

## INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Anthem when applying for initial participation in one or more of Anthem's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at [www.CAQH.org](http://www.CAQH.org).

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

### A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations <ul style="list-style-type: none"><li>The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.</li></ul>
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

### B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance

Medicare certification, if applicable

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Department of Health Survey Results or recognized accrediting organization certification

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License sanctions or limitations, if applicable

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Medicare, Medicaid or FEHBP sanctions

## **RE-CREDENTIALING**

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

## **HEALTH DELIVERY ORGANIZATIONS**

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Anthem Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

## **ONGOING SANCTION MONITORING**

To support certain Credentialing Standards between the re-credentialing cycles, Anthem has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments



- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Anthem departments
- Any other information received from sources deemed reliable by Anthem.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

## **APPEALS PROCESS**

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Anthem's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

## **REPORTING REQUIREMENTS**

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Anthem may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

# ANTHEM CREDENTIALING PROGRAM STANDARDS

## Eligibility Criteria

### A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Anthem.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
  - a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
    - i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
    - ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
    - iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their

specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

- b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegates to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.
5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

#### Criteria for Selecting Practitioners

##### New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the

practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.

10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
  - a. It can be verified that this application is pending.
  - b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
  - c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
  - d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
    - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

- a. It can be verified that the applicant's application is pending; and
- b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
- c. The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
- d. Anthem will verify the appropriate DEA/CDS registration via standard sources; and
- e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

- a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
- b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
- c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as

requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.

12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
  - a. Investment or business interest in ancillary services, equipment or supplies;
  - b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
  - c. Voluntary surrender of state license related to relocation or nonuse of said license;
  - d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
  - e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
  - f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
  - g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
  - h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

#### Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
  - a. Master or doctoral degree in social work.
  - b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
  - c. Licensure to practice independently.
2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
  - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
  - b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
  - c. Practitioners with PhD training as a clinical psychologist can be reviewed.
  - d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
  - e. Licensure to practice independently or in states without licensure or certification:
    - i. Marriage & Family Therapists with a master's degree or higher:
      - a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
    - ii. Mental Health Counselors with a master's degree or higher:
      - a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).
3. Pastoral Counselors:
  - a. Master's or doctoral degree in a mental health discipline.
  - b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
  - c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].
4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
  - a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
  - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
  - c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of

- the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
- d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.
4. Clinical Psychologists:
    - a. Valid state clinical psychologist license.
    - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    - c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
  5. Clinical Neuropsychologist:
    - a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    - b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    - c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      - i. Transcript of applicable pre-doctoral training;
      - ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      - iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.
  6. Licensed Psychoanalysts:
    - a. Applies only to practitioners in states that license psychoanalysts.
    - b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Anthem Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
    - c. Practitioner must possess a valid psychoanalysis state license.
      - (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      - (b) Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements and Verification – Nurse Practitioners:

- a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
- e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
  - i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
  - ii. American Academy of Nurse Practitioners – Certification Program;
  - iii. National Certification Corporation;
  - iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
  - v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
  - vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

- f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
- g. The NP applicant will undergo the standard credentialing processes outlined in Anthem's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-



- credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the NP may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
  - i. NPs will be clearly identified:
    - i. On the credentialing file;
    - ii. At presentation to the CC; and
    - iii. Upon notification to network services and to the provider database.
8. Process, Requirements and Verifications – Certified Nurse Midwives:
- a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
  - b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
  - c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
  - d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
  - e. All CNM applicants will be certified by either:
    - iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    - v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

- j. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges

held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

- k. The CNM applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
- l. Upon completion of the credentialing process, the CNM may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- m. CNMs will be clearly identified:
  - i. On the credentialing file;
  - ii. At presentation to the CC; and
  - iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Physician's Assistants (PA):

- a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
- e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Anthem Health Plan and submitted for individual review by the CC.
- f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

- g. The PA applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the PA may be listed in Anthem provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. PA's will be clearly identified:
  - iv. On the credentialing file;
  - v. At presentation to the CC; and
  - vi. Upon notification to network services and to the provider database.

#### Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Anthem's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. \*No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice

- history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
  14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    - a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    - b. Voluntary surrender of state license related to relocation or nonuse of said license;
    - c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    - d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    - e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    - f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    - g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
  15. No quality improvement data or other performance data including complaints above the set threshold.
  16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Anthem standards.

\*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

## B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Anthem may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

1. General Criteria for HDOs:
  - a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
  - b. Valid and current Medicare certification.
  - c. Must not be currently federally sanctioned, debarred or excluded from participation in

any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.

- d. Liability insurance acceptable to Anthem.
- e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

## 2. Additional Participation Criteria for HDO by Provider Type:

### HDO TYPE AND ANTHEM APPROVED ACCREDITING AGENT(S)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

## NQTL SELF COMPLIANCE TOOL

1. Identify the NQTL: **Formulary Development**
2. Identify the factors considered in the design of the NQTL:
  - Food and Drug Administration (FDA) approved prescribing information, especially indications;
  - Critically and/or scientifically validated findings;
  - Information in major or peer-reviewed medical publications;
  - Recommendations of recognized expert organizations, including specialty clinical societies, academic medical centers and treatment guidelines; and/or
  - Practice pattern and utilization data
  - Effectiveness data, when available
  - Safety
  - Clinical attributes
    - Clinical Attributes are any characteristic of a drug product that differentiates it from alternative products (e.g., pharmacokinetic parameters, once-daily dosing, oral dosing, tablet size, availability of pediatric dosages and dosage forms, FDA-approved indications).
3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Anthem's pharmacy services are provided by its PBM, IngenioRx. Developing the formulary is a two part process. The clinical work, which is the initial step, is done by the IngenioRx Pharmacy and Therapeutics Committee ("P&T"), which meets at least quarterly. The VAC handles the second step, which includes tiering, step therapy, and clinical UM edits (e.g., prior authorization). The policies, procedures, effectiveness data, Clinical Attributes, and other factors considered by the P&T in determining its recommendations with respect to mental health and substance use disorder drugs and drug classes shall be comparable to, and not more stringent than, those applied to medical/surgical drugs and drug classes.

P&T voting members come from various clinical specialties and geographic regions that adequately represent the needs of the enrollees of IngenioRx and the health plans under contract with IngenioRx ("Delegating Entities"). All of the P&T voting members are practicing physicians, including one psychiatrist, or pharmacists who are in good standing with IngenioRx or Anthem. In addition, voting members of the P&T are not employees of IngenioRx or Anthem. A "practicing physician or pharmacist" is an individual who has an active professional license to practice in the United States or one of its territories and either 1) is currently practicing in the United States or one of its territories, or 2) is currently a professor at an academic medical center or school of pharmacy.

- a. At least one voting member of the P&T is a practicing physician who is an expert in the care of elderly or disabled persons.



- b. At least two voting members of the P&T are practicing pharmacists, one of which is an expert in the care of elderly or disabled persons.

The P&T may have subcommittees that address specific topics, including behavioral health (chaired by the psychiatrist that votes on the P&T), drug utilization and policy review, in order to assist the full P&T in its decision making process.

New drugs, including new uses for existing drugs, indications, and formulations are reviewed by the P&T as follows:

#### **P&T Assignment of Clinical Designation**

The P&T conducts its clinical review and makes a recommendation for formulary consideration to the VAC. Clinical designations will only be assigned for branded products that do not have a generic available. The applicable clinical designations and clinical criteria that the P&T may assign are as follows:

##### ***Favorable***

The Favorable clinical designation means that, based upon the data available at the time of the review, the drug provides a better overall treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options.

Designating a product Favorable relative to other drugs in a therapeutic class will be based on a review of the following criteria:

It has clinically recognized and scientifically validated data supporting or demonstrating better:

Efficacy

Safety

Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or

Clinical attribute(s) relative to comparator products.

##### ***Comparable***

The Comparable clinical designation means that, based upon the data available at the time of the review, the drug provides a comparable treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Comparable relative to other drugs in a therapeutic class will be based on a review of the following criteria:





It has clinically recognized and scientifically validated data supporting or demonstrating comparable:

Efficacy

Safety

Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or

Clinical attribute(s) relative to comparator products.

### ***Insufficient Evidence***

The Insufficient Evidence clinical designation means that, based upon the data available at the time of the review, the drug has an unclear treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Insufficient Evidence relative to other drugs in a therapeutic class will be based on a review of the following criteria:

There is a lack of clinically recognized and scientifically validated data supporting or demonstrating:

Efficacy

Safety

Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or

Clinical attribute(s) relative to comparator products.

### ***Unfavorable***

The Unfavorable clinical designation means that, based upon the data available at the time of the review, the drug provides an unfavorable treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options.

Designating a product Unfavorable relative to other drugs in a therapeutic class will be based on a review of the following criteria:

It has clinically recognized and scientifically validated data supporting or demonstrating unfavorable:

Efficacy

Safety



Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or

Clinical attribute(s) relative to comparator products

### ***Lack of a Comparator Product***

In cases where no other pharmacotherapeutic option exists, the "comparator product" listed in the clinical designations above shall become usual care.

### ***Multiple Indications for a Product***

Drugs can only receive one clinical designation. When a drug has multiple uses (indications), the clinical designation will be based on the indication for the majority of individuals using the drug. Other indications for a drug may be addressed in the clinical comments.

### ***Multiple Drug Regimens***

There are diseases where a treatment with a multiple drug regimen is required rather than an individual drug. These regimens will be given a clinical designation as outlined above since the entire regimen is the standard of care rather than individual drugs. The same P&T recommendation guidelines for formulary consideration to the VAC will apply to the designations of regimens.

#### ***P&T Clinical Comments***

The P&T may also, as part of its clinical review, make substantive clinical comments about the products under review or issues pertaining to the therapy of a disease the drug(s) is/are used to treat. These comments are intended to provide the VAC with additional considerations beyond the clinical designations. Clinical comments may be used by the P&T to highlight important safety, efficacy, or clinical attribute concerns. For example, clinical comments may be used to provide further detail supporting a clinical designation, to further differentiate important clinical points between products given the same clinical designation, or to emphasize key clinical concerns in the treatment of a disease state pertaining to the choice of drug therapy.

#### ***Generic Drug Products***

While the P&T review includes generic drug products, clinical designations will not be made for these products because the tier of these products is generally based on member certificate language and/or the multisource brand policy of IngenioRx. However, the P&T may provide the VAC with clinical comments on these products that are based on safety and/or efficacy concerns.

### **P&T Assignment of Clinical Criteria**

The P&T determines that, for reasons of safety and/or efficacy, Clinical Criteria are necessary to promote clinically appropriate use. The P&T shall review and approve such necessary Clinical Criteria.



These would include, but not be limited to, clinical edits such as prior authorization, step therapy, quantity limitations, dose optimization, and duplicate therapy.

**The P&T clinical review includes, but is not limited to, the following:**

- Food and Drug Administration (FDA) approved uses;
- FDA approved package inserts;
- Critically and/or scientifically validated findings;
- Information in major or peer-reviewed medical publications;
- Recommendations of recognized expert organizations, including specialty clinical societies, academic medical centers and treatment guidelines; and/or
- Practice pattern and utilization data.

**The P&T may NOT include or consider the following:**

- Rebates or potential rebates, or any other contractual arrangement or relationship with a pharmaceutical manufacturer;
- Drug cost to the health plan, member or risk bearing entity;
- Any economic cost or benefit
- Benefit types and/or
- Any other considerations that are not relevant to the clinical aspects of therapy.

P&T recommendation(s) which includes clinical designations of the comparability of products and clinical criteria are forwarded to the Value Assessment Committee (VAC) for formulary/tier assignment or formulary/tier edits.

**Tiering**

Deciding what tier a formulary approved drug belongs on is handled by the Value Assessment Committee ("VAC"). For new drugs, the following is considered:

The VAC must make a reasonable effort to review and determine Tiering of a new FDA approved drug product (or new FDA approved indication) within 180 days of its release onto the market. For Medicare Part D, the VAC will follow CMS-mandated timeframes. For special circumstances such as high-impact medications, the chairperson may decide to call an ad hoc meeting.

Expedited review: New drugs or newly approved uses for drugs within six Medicare Part D protected clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic) must be reviewed and a Tiering decision made within 90 days. To the extent needed, document presentation will be made at the next regular meeting to ensure compliance with CMS timelines.



## VAC DECISION-MAKING GUIDELINES

### Formulary/Non-Formulary Determinations:

For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or non-formulary status. The VAC abides by all recommended Clinical Designations and Clinical Criteria of the P&T.

### Tiering Determinations:

There are three parts to the VAC review and corresponding Tier assignment. The first and second parts of the VAC review identify what **MUST** be considered in the review and Tiering process, and the third part of the process identifies what **MAY** be taken into account during the review and Tiering process. The P&T's Clinical Designation, Clinical Comments or Clinical Criteria will be reviewed by the VAC before Tier placement is determined.

**First:** The VAC review and Tiering process **MUST** take into account the *Clinical Designations* made by the P&T. This means that the VAC cannot place a drug with a weaker Clinical Designation on a lower Tier than another drug with a stronger Clinical Designation; however, Insufficient Evidence and Unfavorable designations will be considered equivalent when Tiering products.<sup>1</sup> The following illustrates the hierarchy:

- Drugs that are designated Favorable have the greatest clinical value. Favorable drugs have a greater clinical value than drugs designated as Comparable, Insufficient Evidence, or Unfavorable;
- Drugs that are designated Comparable have a greater clinical value than drugs designated as Insufficient Evidence or Unfavorable; and
- Drugs that are designated as Insufficient Evidence have unclear clinical value, while drugs that are designated as Unfavorable have weak clinical value.

Drugs classified as Comparable may be placed in the same tier as drugs classified as Favorable or those classified as Insufficient Evidence or Unfavorable. However, drugs classified as Favorable cannot be placed in the same tier as drugs classified as Insufficient Evidence or Unfavorable unless a step edit is also implemented. In addition, drugs classified as Favorable cannot be placed in a higher tier than drugs classified as Comparable and drugs classified as Comparable cannot be placed in a higher tier than drugs classified as Insufficient Evidence or Unfavorable.

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<sup>1</sup> Please note that Tier 1 is considered the lowest Tier (meaning it has the lowest copay or coinsurance associated with it), and, in a 3-Tier formulary, Tier 3 is considered the highest Tier (meaning it has the highest copay or coinsurance associated with it).

Clinical Edits on products will follow similar rules. Drugs classified as Favorable will not be subject to greater edits than those classified as Comparable, Insufficient Evidence, or Unfavorable and drugs classified as Comparable will not be subject to greater edits than those classified as Insufficient Evidence or Unfavorable.

Notwithstanding the prior two paragraphs, there are specific unique circumstances where VAC may not need to adhere to the above tiering and/or editing limitations. This may occur:

1. Only when explicitly supported by P&T in its clinical comments AND only for one of the following situations:
  - a. When P&T has designated multiple drugs with the same active ingredient(s) which is available in different formulations/delivery methods and the different formulations/delivery methods are given the same designation by P&T OR
  - b. When P&T has designated in a therapeutic grouping that multiple drugs in that grouping are clinically similar, but the differentiation in the designation given by P&T is based on the formulation/delivery method and there are attributes that P&T determines may be clinically beneficial based on formulation/delivery methodOR
2. Federal and State laws, and the requirements of those laws take precedence over the VAC rules and when specific drugs are required for inclusion in a formulary, the Formulary regarding these drugs will follow all applicable Federal and State laws. However, such a requirement of law for inclusion of such a drug will not trigger i) a requirement that all drugs with a more favorable designation be included on the formulary ii) nor that all drugs with a more favorable designation be preferred in tiering and/or in edits.
3. For a formulary developed for use by Administrative Services Only (ASO) clients, the tier placement and edit determinations may allow selective product choice that provides flexibility and affordability. Inclusion of a drug with a lesser designation than other comparator drugs will not trigger i) a Charter requirement that all drugs with a more favorable designation be included on the formulary or preferred in edits; and ii) nor that all drugs with a more favorable designation be preferred in tiering and/or in edits. Notwithstanding the previous sentence, Insufficient evidence and Unfavorable drugs cannot be the sole drugs in a formulary category, unless all drugs in the category are Insufficient Evidence or Unfavorable. In addition, nor can Insufficient Evidence or Unfavorable drugs be favored over drugs with a Favorable Clinical Designation by formulary status, tier placement or edits.

Edits that are recommended by the delegating entities and reviewed by P&T based on safety concerns (e.g., Drug-Drug interactions) will be identified for the VAC by the Clinical team. The VAC will either approve such edits or send back to the P&T for further guidance on the P&T's decision.

**Second:** In addition to the Clinical Designations, the VAC **MUST** also take into account the member impact associated with drug Tiering and edits. The VAC must demonstrate that the member impact has been appropriately considered relative to financial factors. Accordingly, the VAC should consider the following issues before making any Tiering recommendations:

- Member and provider disruption from a clinical and financial perspective;
- Operational and public policy impact from a clinical and financial perspective; and
- Generic and OTC availability.
- Grievance and appeal experience

**Third:** The VAC review and Tiering process **MAY** include, but is not limited to, the following:

- Clinical Comments from the P&T
- Relevant financial information or impact on the health plan, member, group or other party at financial risk (including average wholesale price, ingredient cost, cost of care, copays, coinsurance, rebates);
- Potential provider impact or disruption;
- Market factors (including product market share, anticipated product/category growth, direct to consumer advertisement, and/or competitive environment);
- Health and economic outcomes relative to comparator products; Patent expirations, generic availability, over-the-counter availability and relative access to the drug; and

Based upon the information derived from the above review, the VAC shall assign covered products to applicable Tiers. Other than the Clinical Designation made by the P&T, it is up to the members of the VAC to determine what value and/or weight shall be assigned to the factors considered.

VAC Procedures:

Approval is by a simple majority vote of the VAC voting members. Once a simple majority of the members of the VAC agree on the formulary and/or Tier assignment for a covered



product, then that approval shall be sent to the applicable delegated entity for action by each delegating entity in accordance with their applicable policies and procedures.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

The processes and criteria outlined above apply to all drugs/therapies including medical/surgical and mental health/substance abuse drugs.

#### Comparative Analysis

To determine whether the formulary treats behavioral health conditions no less stringently than medical/surgical conditions, Anthem analyzed the tiering. As demonstrated by the chart below, the National Formulary, which is our most used formulary, tiers a greater percentage of overall drugs used to treat a behavioral health condition in lower tiers than drugs approved by the FDA to treat medical/surgical condition. There are a total of 123,132 drugs and medical supplies (e.g., syringes) (medical surgical = 116,221 and behavioral health = 6,911) that are available to be included on the formulary.

	Tier 1	Tier 2	Tier 3	Tier 4	NonFormulary/Noncovered
Behavioral Health (Mental Health/Substance Use Disorder)	48.2%	1.3%	29.4%	2.3%	18.8%
Non- Behavioral Health	15.8%	11.0%	46.8%	4.2%	22.2%

Anthem also reviewed the number of behavioral health drugs that are subject to step therapy or prior authorization as compared to medical surgical drugs.

	Total NDC Codes	NDC codes reviewed	Prior Auth	Step Therapy	Percent reviewed
Behavioral Health (Mental Health/Substance Use Disorder)	5459	608	375	233	11%
Non- Behavioral Health	48,648	9,445	4,404	5,041	19%

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. IngenioRx utilizes the same process and procedures to determine what mental health/substance abuse treatment drugs are on the formulary as used for drugs to treat medical/surgical conditions. A greater percentage of drugs are in Tier 1 for MH/SUD than for medical/surgical. Additionally, IngenioRx requires a review, whether prior authorization or step therapy, on smaller percentage of MH/SUD drugs than medical/surgical.



Therefore, IngenioRx's process for creating its formulary and administering its formulary is in compliance with MHPAEA.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



# MCG Development Processes and Evidentiary Standards: Behavioral Health Care (BHG)

MCG Health develops all of its content for the clinical care of patients, including medical, surgical, and behavioral health, using the same methods. This document specifically addresses MCG Behavioral Health Care content, which is developed using the following criteria:

## **The guidelines and clinical criteria are clearly defined.**

Each guideline has specific care guidance regarding a diagnosis, procedure, or level of care. The guidelines apply to the assessment and management of patients with behavioral health needs. Separate guidelines and content pieces address adult and child or adolescent populations.

## **Target users and how they will use guidelines are clearly defined.**

MCG Behavioral Health Care content provides evidence-based guidelines to help healthcare professionals guide the effective treatment of patients with mental health and substance use disorders across the continuum of care.

Our client base (users) includes entities representing all aspects of healthcare: payers (e.g., insurance companies), providers (e.g., hospitals, physician groups), and government agencies (e.g., Centers for Medicare and Medicaid Services and contractor organizations). The purpose of the care guidelines is to identify optimal patient care and recovery as one means of enhancing the delivery of quality healthcare and promoting more efficient resource management across the continuum of care.

We provide a description of each guideline section and comment on its potential use. The guidelines can assist physicians, case managers, and other mental healthcare professionals in identifying indications for use of levels of care, developing outpatient alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for the transition of patients from one level of care to another. The guidelines address 5 different levels of care (inpatient care, residential care, partial hospital program, intensive outpatient program, and outpatient care).

MCG Behavioral Health Care content also provides evidence-based guidelines for opioid management, specialty medications, community services, testing, and therapeutic services. The care guidelines can enhance the delivery of optimal healthcare and promote more efficient resource management.

## **Strengths and limitations of the body of evidence used have been identified and disclosed to users.**

A summary of the guideline development policies and procedures is included in the Methodology Information section on the home page of the MCG Behavioral Health Care guidelines and is available to all users.

## **Systematic methods are used to search for evidence.**

Search algorithms are used to identify all the available medical literature for the topic covered by each guideline. All retrieved publications are individually reviewed by Physician and Nurse Editors and assessed in terms of quality, utility, and relevance in supporting best practices in achieving effective care. The general criteria used for this selection process include finding publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals (i.e., journals that are read and cited most often within their field).
3. Address an aspect of specific importance to the guideline in question (e.g., admission criteria, length of stay).
4. Represent an update or contain new data or information not reflected in the current guideline.
5. Reflect the highest standard of care of treatment for a specific condition or population.

The care guidelines are developed in accordance with the principles of evidence-based medicine. The evidence base is evaluated and graded according to our standardized hierarchy:

### **Evidence Grade 1:**

- Meta-analyses
- Randomized controlled trials with meta-analysis
- Randomized controlled trials
- Systematic reviews

### **Evidence Grade 2:**

- Observational studies; examples include:
  - Cohort studies with statistical adjustment for potential confounders
  - Cohort studies without adjustment
  - Case series with historical or literature controls
  - Uncontrolled case series
- Published guidelines
- Statements in published articles or textbooks

### **Evidence Grade 3:**

- Unpublished data; examples include:
  - Large database analyses
  - Written protocols or outcomes reports from large practices
  - Expert practitioner reports

## **Health benefits, side effects, and risks are considered in formulating the guidelines.**

Guidance is provided regarding best practice and effective care, which includes consideration of the necessary resources, avoiding unnecessary resource use, the benefits of treatment, possible side effects, and risks to the patient. Evidence supporting each guideline is cited with the relevant content. When applicable (and available), the published abstract is also provided.

## **There is an explicit link between the guidelines and the supporting criteria.**

A systematic query of the National Library of Medicine database via the PubMed search engine is performed (annually at a minimum) for each guideline using specially developed, customized, tested, proprietary search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximize retrieval of articles with certain desired characteristics pertinent to a guideline. For example, some of the guideline searches preferentially seek randomized controlled trials, systematic reviews, published clinical guidelines, and publications related to inpatient length of stay or potential appropriateness of outpatient patient care. As previously noted, evidence supporting each guideline is cited with the relevant content.

## **Independent and appropriate clinical staff are involved in the development process.**

Physician and Nurse Editors evaluate all output from literature searches and select articles for use in writing and updating the guidelines. In addition, throughout the annual production cycle, MCG medical librarians and clinical editors track newly released or updated guidelines from outside sources (e.g., professional specialty societies, Cochrane Reviews), as well as new editions of textbooks. Relevant new content is incorporated into all guidelines as appropriate. Each updated guideline is then reviewed by a Managing Editor to verify the accuracy and appropriateness of all changes. Finally, each guideline is copyedited and reviewed for quality control and technical accuracy.

The development, writing, and updating process for any given guideline uses Physician and Nurse Editors, Physician Managing Editors, medical librarians, copy editors, and statistical analysts. For Behavioral Health Care, all positions involved in this process at this time, with the exception of statistical analysts, are MCG employees. Our content is evidence-based and referenced rather than consensus-based.

## **The development group includes experts from all relevant professional groups.**

The development group involved in the MCG Behavioral Health Care content includes Physician Editors (board-certified physicians, including a board-certified psychiatrist, are involved in the annual writing and updating of the Behavioral Health Care content), Nurse Editors, Managing Editors, medical librarians, copy editors, and statistical analysts.

**Proposed criteria are reviewed and tested by independent experts, and the process requires that a consensus be reached.**

Outside experts are used to review guidelines after they are written. Each guideline undergoes external review by clinically active experts (e.g., board-certified specialist physicians) chosen based on demonstrated clinical expertise in their field (curriculum vitae and other sources, documentation of licensure, and continued specialty practice). The review is intended to confirm the clinical appropriateness, accuracy, validity, and applicability of each guideline. The Managing Editor evaluates all comments from these external reviewers and makes changes to the guideline if needed. In addition, about 10 weeks prior to the annual release of a new edition, we allow customer preview access and use any comments received as additional input, when applicable, to modify/improve content.

**Discussions of guidelines are documented, and conflicting or competing interests are recorded and addressed.**

External peer review feedback is provided to MCG in a written format that is posted in the MCG database. This feedback, as well as incorporation into guideline content, is maintained by MCG. Neither MCG nor its employees accept any funding or remuneration from outside sources to support or influence guideline development. All participants in the guideline development and outside review processes complete Conflict of Interest statements. Any identified conflicts are addressed.

**Guidelines are reviewed and updated at a minimum annually.**

Every guideline undergoes an updating process annually.

**The funding body should not have undue influence over the content of the guidelines.**

As previously noted, neither MCG nor its employees accept any funding or remuneration from outside sources to support or influence guideline development. All participants in the guideline development and outside review processes complete Conflict of Interest statements. Any identified conflicts are addressed.

**The overall objectives of the guidelines are specifically described.**

The purpose of the Level of Care Guidelines is to identify benchmark patient care and recovery as one means of enhancing the delivery of quality healthcare and promoting more efficient resource management across the continuum of care. The appropriateness of specific psychological, behavioral, and pharmacologic therapies is addressed to help define the optimal level of care of effective, efficient behavioral health therapy. Indications are presented in guidelines that cover care for all DSM-5 codes in 5 different levels of care (inpatient care, residential care, partial hospital program, intensive outpatient program, and outpatient care); guidelines for the diagnosis of delirium are limited to the inpatient level of care. The guidelines can assist in tracking patient progress during treatment within a level of care, facilitating the

progress of patients whose recovery is delayed, and preparing comprehensive plans for the transition of patients from one level of care to another.

Other guidelines within the MCG Behavioral Health Care content address the assessment, treatment, and management of behavioral health conditions outside of facilities.

**The health questions covered by the guidelines are specifically described.**

Diagnosis-specific and procedure-specific content, as well as specific content related to Therapeutic Services, Testing Procedures, Opioid Management, and Specialty Medications, is provided in the guidelines. The population to whom each guideline applies is specifically described.

**The criteria are specific and unambiguous.**

Each guideline has specific care guidance regarding a diagnosis, procedure, or level of care. The guidelines apply to the assessment and management of clinical care for patients with behavioral health disorders.

**All options for management of a condition or health issue are clearly presented.**

Alternative levels of care and treatment options are presented and discussed within the Level of Care Guidelines. Footnotes and instructional tools provide information on implementation of the guidance.

**The guidelines provide advice or tools on how the recommendations can be put into practice.**

The guidelines are designed to be actionable, provide definitions for clinical terms used, and contain specific criteria sets with internal logic operators that result in a Criteria Met (Yes) or Not Met (No) outcome based on user input of the specific patient parameters.

**The guidelines describe any facilitators and barriers to the application of the specific guidelines.**

Each level of care guideline provides a discussion of the chosen and alternative levels of care and its implementation. Alternative Care Planning, Care Planning, and Discharge Planning sections all describe steps to facilitate the care needed and overcome barriers to its implementation.

**Any potential resource implications of applying the recommendation are noted and considered in the guidelines.**

The guidelines are produced to reflect best practice and promote effective and integrative care. A core feature of the development process (and thus the guideline recommendations) is consideration of the appropriate use of resources needed for the achievement of optimal patient care.

Each level of care guideline has information regarding admission criteria, recovery course milestones, and discharge. All can be used to assess and monitor patient needs, progress during treatment, and readiness for alternative levels of treatment. Use of the guidelines with our interactive software allows the creation of reports and auditing of progress at the patient level and performance at the health system level. Recovery courses list expected interventions (assessments and treatments) to monitor patient care and promote conversations about the appropriateness of, progress in, and possible need for alteration of care plans. Statistical benchmarks based on analysis of national population sample data are provided for metrics such as length of stay to assist in assessing and monitoring care at the patient, provider, and population levels.

### **The guidelines are based on independently monitored and audited criteria.**

The Level of Care Guidelines are based on independently monitored and audited criteria from a variety of widely recognized sources, including but not limited to the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, Association for Ambulatory Behavioral Healthcare, American Association of Community Psychiatrists, and American Society of Addiction Medicine. MCG content is in alignment with and supplements criteria published by these and other nationally recognized behavioral health care organizations, and source materials developed by these organizations, including but not limited to practice parameters and best practice guidelines, are extensively referenced in the guidelines.

### **The criteria span all aspects of the continuum of care.**

The Behavioral Health Care guidelines address 5 levels of care (inpatient care, residential care, partial hospital program, intensive outpatient program, and outpatient care). Guidelines for the treatment of behavioral health care conditions in Home Care and Recovery Facility settings are also included in the MCG Behavioral Health Care content. In addition, MCG Behavioral Health Care content includes guidelines for services that often are provided in community settings (e.g., Applied Behavioral Analysis, Assertive Community Treatment, Targeted Case Management, Psychosocial Rehabilitation, Peer Support Services, Mental Health Support Services, Social Skills Training, Therapeutic Behavioral On-Site Services, and Psychological Testing) and other levels of care (e.g., crisis intervention, observation, day treatment, long-term community-based residential, and custodial care).

### **The criteria incorporate a safety risk assessment.**

Safety risk assessments, including assessments of risk to self or others, as well as patient functional status and its impact on the appropriate level of care, are integral parts of level of care guideline criteria.

### **The criteria incorporate a social determinants of health assessment.**

A social determinants of health assessment is used to help identify patients at higher risk for an unmet health-related social need. The assessment covers housing insecurity, food insecurity, insufficient transportation, insufficient utilities, personal safety risk, insufficient dependent care, and depression risk.

**The criteria address dual diagnosis, comorbidity, or nonspecific diagnosis as appropriate.**

Implications regarding care for dual-diagnosis patients with comorbidity are discussed in the Level of Care Guidelines. Multiple sets of nonspecific diagnosis-based Level of Care Guidelines are available for situations (often intake assessments) in which care is clinically indicated but the exact psychiatric diagnosis is yet to be determined. Generic nonspecific diagnosis guideline sets are also available.

**For treatment of a substance use disorder, the clinical review criteria are based on independently monitored and audited criteria.**

The MCG Behavioral Health Care guideline content is in alignment with, and extensively references, the most recent American Society of Addiction Medicine edition (2013), and this guideline, along with other substance use guidelines (including, but not limited to, guidelines from the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Association of Community Psychiatrists, and Association for Ambulatory Behavioral Healthcare), are extensively referenced in the content.

**For treatment of a child or adolescent mental disorder, the clinical review criteria are based on independently monitored and audited criteria.**

The MCG Behavioral Health Care level of care guideline content is in alignment with, and extensively references, the most recent version (2014) of the Child and Adolescent Service Intensity Instrument (CASII), as well as the Early Childhood Service Intensity Instrument (ECSII) and the Child and Adolescent Level of Care Utilization System (CALOCUS), along with numerous other best practice sources, including, but not limited to, practice parameters from the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association.

**For treatment of an adult mental disorder, the clinical review criteria are based on independently monitored and audited criteria.**

The MCG Behavioral Health Care level of care guideline content was developed in alignment with the American Psychiatric Association (APA) Criteria for Short-Term Treatment of Acute Psychiatric Illness (1997, affirmed 2011). Given that the most recent APA review criteria reference DSM-IV rather than DSM-5, current MCG content for the management of adults with mental health disorders is in alignment with, and extensively references, numerous other best practice sources, including, but not limited to, more recent APA practice guidelines, the most recent Association for Ambulatory Behavioral Healthcare content (2018 AABH Standards and Guidelines), and the Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services published by the American Association of Community Psychiatrists.



## **Mental Health Parity**

MCG care guidelines, including MCG Behavioral Health Care guidelines, align with regulatory requirements, including the Mental Health Parity and Addiction Act (MHPAEA). The development methods for mental health and substance use disorders (MHSUDs) and medical/surgical content are the same. All MCG guidelines for MHSUDs, including those in the MCG Behavioral Health Care content as well as in the MCG medical/surgical content, address quantitative and nonquantitative treatment limitations in the same manner.

Level of care guidelines for MHSUD content and medical/surgical topics include an optimal recovery course. When evidence is available to provide guidance about a goal length of stay, or there is historical data about the number of visits for a specific diagnosis, this information is provided in the same way for MHSUD and medical/surgical content. There are no “fail-first” requirements for Clinical Indications for Admission for MHSUD level of care content.

MCG care guidelines related to procedures, treatments, and medications may require a trial of conservative treatment (i.e., medication) based on published evidence. These nonquantitative treatment limitations are based solely on the published medical literature; limitations on duration or scope of treatment are derived from the best available evidence and are written similarly across MHSUD and medical/surgical content.



# MCG Development Processes and Evidentiary Standards: Inpatient & Surgical Care

MCG Health develops all of its content for the clinical care of patients, including medical, surgical, and behavioral health, using the same methods. This document specifically addresses MCG Inpatient & Surgical Care content, which is developed using the following criteria:

## **The guidelines and clinical criteria are clearly defined.**

Each guideline has specific care guidance regarding a diagnosis, level of care, or treatment modality. The guidelines apply to the assessment and management of medical and surgical patients. Separate guidelines and content pieces address adult and child or adolescent, as well as neonatal, populations.

## **Target users and how they will use guidelines are clearly defined.**

MCG Inpatient & Surgical Care content provides evidence-based guidelines to help healthcare professionals guide the effective treatment of patients with medical and surgical conditions.

Our client base (users) includes entities representing all aspects of healthcare: payers (e.g., insurance companies), providers (e.g., hospitals, physician groups), and government agencies (e.g., Centers for Medicare and Medicaid Services and contractor organizations). The purpose of the care guidelines is to identify optimal patient care and recovery as one means of enhancing the delivery of quality healthcare and promoting more efficient resource management across the continuum of care.

We provide a description of each guideline section and comment on its potential use. The guidelines can assist physicians, case managers, and other healthcare professionals in identifying indications for use of levels of care, identifying appropriateness of inpatient and observation levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for the transition of patients from one level of care to another. The guidelines address a variety of inpatient levels of care (general admission, as well as intensive, intermediate, and telemetry levels of care).

## **Strengths and limitations of the body of evidence used have been identified and disclosed to users.**

A summary of the guideline development policies and procedures is included in the Methodology Information section on the home page of the MCG Inpatient & Surgical Care guidelines and is available to all users.

## **Systematic methods are used to search for evidence.**

Search algorithms are used to identify all the available medical literature for the topic covered by each guideline. All retrieved publications are individually reviewed by Physician and Nurse Editors and assessed in terms of quality, utility, and relevance in supporting best practices in achieving effective care. The general criteria used for this selection process include finding publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals (i.e., journals that are read and cited most often within their field).
3. Address an aspect of specific importance to the guideline in question (e.g., admission criteria, length of stay).
4. Represent an update or contain new data or information not reflected in the current guideline.

The care guidelines are developed in accordance with the principles of evidence-based medicine. The evidence base is evaluated and graded according to our standardized hierarchy:

### **Evidence Grade 1:**

- Meta-analyses
- Randomized controlled trials with meta-analysis
- Randomized controlled trials
- Systematic reviews

### **Evidence Grade 2:**

- Observational studies; examples include:
  - Cohort studies with statistical adjustment for potential confounders
  - Cohort studies without adjustment
  - Case series with historical or literature controls
  - Uncontrolled case series
- Published guidelines
- Statements in published articles or textbooks

### **Evidence Grade 3:**

- Unpublished data; examples include:
  - Large database analyses
  - Written protocols or outcomes reports from large practices
  - Expert practitioner reports

## **Health benefits, side effects, and risks are considered in formulating the guidelines.**

Guidance is provided regarding best practice and effective care, which includes consideration of the necessary resources, avoiding unnecessary resource use, the benefits of treatment, possible side effects, and risks to the patient. Evidence supporting each guideline is cited next to the relevant content. When applicable (and available), the published abstract is also provided.

## **There is an explicit link between the guidelines and the supporting criteria.**

A systematic query of the National Library of Medicine database via the PubMed search engine is performed (annually at a minimum) for each guideline using specially developed, customized, tested, proprietary search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximize retrieval of articles with certain desired characteristics pertinent to a guideline. For example, some of the guideline searches preferentially seek randomized controlled trials, systematic reviews, published clinical guidelines, and publications related to inpatient length of stay or potential appropriateness of ambulatory patient care. As previously noted, evidence supporting each guideline is cited next to the relevant content.

## **Independent and appropriate clinical staff are involved in the development process.**

Physician and Nurse Editors evaluate all output from literature searches and select articles for use in writing and updating the guidelines. In addition, throughout the annual production cycle, MCG medical librarians and clinical editors track newly released or updated guidelines from outside sources (e.g., medical specialty societies, Cochrane Reviews), as well as new editions of textbooks. Relevant new content is incorporated into all guidelines as appropriate. Each updated guideline is then reviewed by a Managing Editor to verify the accuracy and appropriateness of all changes. Finally, each guideline is copyedited and reviewed for quality control and technical accuracy.

The development, writing, and updating process for any given guideline uses Physician and Nurse Editors, Physician Managing Editors, medical librarians, copy editors, and statistical analysts. For Inpatient & Surgical Care guidelines, all positions involved in this process at this time, with the exception of statistical analysts, are MCG employees. Our content is evidence-based and referenced rather than consensus-based.

## **The development group includes experts from all relevant professional groups.**

The development group involved in the MCG Inpatient & Surgical Care content includes Physician Editors (board-certified physicians are involved in the annual writing and updating of the Inpatient & Surgical Care content), Nurse Editors, Managing Editors (Physician and Nurse

Managing Editors are involved in medical and surgical content), medical librarians, copy editors, and statistical analysts.

**Proposed criteria are reviewed and tested by independent experts, and the process requires that a consensus be reached.**

Outside experts are used to review guidelines after they are written. Each guideline undergoes external review by clinically active experts (e.g., board-certified specialist physicians) chosen based on demonstrated clinical expertise in their field (curriculum vitae and other sources, documentation of licensure, and continued specialty practice. The review is intended to confirm the clinical appropriateness, accuracy, validity, and applicability of each guideline. The Managing Editor evaluates all comments from these external reviewers and makes changes to the guideline if needed. In addition, about 10 weeks prior to the annual release of a new edition, we allow customer preview access and use any comments received as additional input, when applicable, to modify/improve content.

**Discussions of guidelines are documented, and conflicting or competing interests are recorded and addressed.**

External peer review feedback is provided to MCG in a written format that is posted in the MCG database. This feedback, as well as its incorporation into guideline content, is maintained over time. Neither MCG nor its employees accept any funding or remuneration from outside sources to support or influence guideline development. All participants in the guideline development and outside review processes complete Conflict of Interest statements. Any identified conflicts are addressed.

**Guidelines are reviewed and updated at a minimum annually.**

Every guideline undergoes an updating process annually.

**The funding body should not have undue influence over the content of the guidelines.**

As previously noted, neither MCG nor its employees accept any funding or remuneration from outside sources to support or influence guideline development. All participants in the guideline development and outside review processes complete Conflict of Interest statements. Any identified conflicts are addressed.

**The overall objectives of the guidelines are specifically described.**

The purpose of the care guidelines is to identify benchmark patient care and recovery as one means of enhancing the delivery of quality healthcare and promoting more efficient resource management across the continuum of care. The appropriateness of specific therapies is addressed, and indications are presented to help define the optimal level of care for effective, efficient inpatient medical and surgical care. The guidelines can assist in tracking patient

progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for the transition of patients from one level of care to another.

**The health questions covered by the guidelines are specifically described.**

Diagnosis-specific content, as well as specific content related to general levels of care (such as intensive, intermediate, and telemetry care guidelines) and specific populations (such as neonatal facility level of care and admission guidelines), is provided in the guidelines. The population to whom each guideline applies is specifically described.

**The criteria are specific and unambiguous.**

Each guideline has specific care guidance regarding a diagnosis or level of care. The guidelines apply to the assessment and management of clinical care for inpatient medical and surgical care patients. Separate guidelines and content pieces address adult, child or adolescent, and neonatal populations.

**All options for management of a condition or health issue are clearly presented.**

Alternative levels of care and treatment options are presented and discussed. Footnotes and instructional tools provide information on the implementation of the guidance.

**The guidelines provide advice or tools on how the recommendations can be put into practice.**

The guidelines are designed to be actionable, provide definitions for clinical terms used, and contain specific criteria sets with internal logic operators that result in a Criteria Met (Yes) or Not Met (No) outcome based on user input of the specific patient parameters.

**The guidelines describe any facilitators and barriers to the application of the specific guidelines.**

Each guideline provides a discussion of the chosen and alternative levels of care and its implementation. Alternative Care Planning, Care Planning, and Discharge Planning sections all describe steps to facilitate the care needed and overcome barriers to its implementation.

**Any potential resource implications of applying the recommendation are noted and considered in the guidelines.**

The guidelines are produced to reflect best practice and promote effective care. A core feature of the development process (and thus the guideline recommendations) is consideration of the resources that are needed for care, achievement of optimal resource care, and avoidance of unnecessary resource use (both in treating the patient and using the guideline).

Each guideline has information regarding admission criteria, recovery course milestones, and discharge to a less intensive level of care. All can be used to assess and monitor patient needs, progress during treatment, and readiness for alternative levels of treatment. Use of the guidelines with our interactive software allows the creation of reports and auditing of progress at the patient level and performance at the health system level. Recovery courses list expected interventions (assessments and treatments) to monitor patient care and promote conversations about the appropriateness of, progress in, and possible need for alteration of care plans. Statistical benchmarks based on analysis of national population sample data are provided for metrics such as length of stay to assist in assessing and monitoring care at the patient, provider, and population levels.

### **The guidelines are based on independently monitored and audited criteria.**

The guidelines are based on independently monitored and audited criteria from a variety of widely recognized sources, including but not limited to practice parameters and best practice guidelines from nationally recognized specialty organizations relevant to the specific diagnosis, level of care, or patient population (e.g., neonates) under consideration, and these source materials are extensively referenced in the guidelines.

### **The criteria span all aspects of the continuum of care.**

The Inpatient & Surgical Care guidelines address inpatient facility care, including acute hospital admission, intensive, intermediate, and telemetry care. Alternatives to inpatient care are included, including outpatient therapy, home care (including multidisciplinary team care), emergency department or other rapid onsite treatment, recovery facility care, skilled nursing facility care, and observation care. Home care, recovery facility care, and chronic care guidance are addressed in greater detail in separate content volumes. Discharge planning guidance to community-based care includes a comprehensive assessment of necessary social and community supports, evaluation for comorbidities, including comorbid substance use disorders, and other factors necessary to promote a safe transition to a less intensive level of care.

### **The criteria incorporate a safety risk assessment.**

Safety risk assessments, including assessments of risk to self or others, as well as patient functional status and its impact on the appropriate level of care, are integral parts of guideline criteria.

### **The criteria incorporate a social determinants of health assessment.**

A social determinants of health assessment is used to help identify patients at higher risk for an unmet health-related social need. The assessment covers housing insecurity, food insecurity, insufficient transportation, insufficient utilities, personal safety risk, insufficient dependent care, and depression risk.

### **The criteria address comorbidities or nonspecific diagnoses as appropriate.**

Implications regarding care for patients with comorbidities (including complicating medical diagnoses, and conditions such as substance use disorders) are discussed in the guidelines. Common Complications and Conditions guidelines are provided to address a variety of nonspecific complications, such as fever and change in mental status. For circumstances in which multiple conditions are associated with extended hospital stays and more complicated courses, Multiple Condition Management guidelines are provided. A separate content volume, the General Recovery Guidelines, covers diagnoses not covered in Inpatient & Surgical Care.

### **The clinical review criteria are based on independently monitored and audited criteria.**

The MCG Inpatient & Surgical Care content references a variety of best practice and specialty sources that are developed independently of MCG.



## **NQTL SELF COMPLIANCE TOOL**

### **Medical Policy and Fail First**

1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply.

*Overview:* This nonquantitative treatment limitation (NQTL) analysis explains how Anthem creates its medical policies and clinical UM guidelines (collectively “medical policies”), including the medical policies that define the criteria Anthem uses to determine what services are considered medically necessary or investigational. Anthem also licenses MCG guidelines for review of medical, surgical and behavioral health services. Anthem approves or modifies MCG guidelines as described below. If a state law requires Anthem to use a different medical criteria, such as InterQual, LOCUS, CALOCUS or ASAM, then Anthem uses those guidelines as written.

Anthem policy and procedure documents include the following:

1. Medical Policy Formation:  
[https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp\\_pw\\_a044135.html](https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp_pw_a044135.html).
2. Medical Necessity Criteria Medical Policy:  
[https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp\\_pw\\_a044145.html](https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp_pw_a044145.html)
3. Investigational Criteria Medical Policy:  
[https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp\\_pw\\_a044153.html](https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp_pw_a044153.html)

Members may access any of the procedure documents and actual Medical Policies and Clinical UM Guidelines in the publicly accessible links above through anthem.com. Plan documents alert members that medical necessity is one aspect to determining coverage for specific services (“Getting Approval for Benefits”). The Plan Documents also provide the following information about “Medical Policy and Technology Assessment”:

“Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem’s medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem’s medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.”

#### **Relevant Definitions:**





**Investigational** – Means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet the Company Technology Evaluation Criteria because it does not meet one or more of the following criteria:

- have final approval from the appropriate government regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings.

**Fail first** – A requirement that before a service is considered to be medically necessary, the member must have first tried and failed a different treatment. In determining whether to require fail first for a particular service or treatment, a component of Medical Policy, Anthem is focused on member safety to ensure options with less risk or are less invasive are considered.

**MPTAC** – Medical Policy & Technology Assessment Committee is the authorizing body for Anthem medical policies and clinical UM guidelines including guidelines developed by MCG which serve as a basis for medical necessity determinations. The MPTAC is a multiple disciplinary group consisting of physicians external to Anthem who are in active academic and community practice, as well as internal Anthem medical directors. Members are from various medical and behavioral health specialties, clinical practice environments and geographic areas. All members are board certified specialists in their respective fields.

**OMPTA** – the Office of Medical Policy & Technology Assessment, a department within Anthem whose associates develop and maintain Anthem medical policies and clinical utilization management (UM) guidelines, and review or propose modification to MCG guidelines, for review and approval by MPTAC.

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

In evaluating whether to develop new medical policy (MP) or clinical UM guideline (CUMG) documents or for pertinent updates to existing MP or CUMG documents, OMPTA solicits input from a variety of internal resources including actuary, analytics, behavioral health, claims processing, cost of care, health care management, legal, and program integrity. Many factors are considered when deciding whether to develop a new document and include but are not limited to why the topic is being considered, relevant scientific evidence, whether codes exist to describe the service, potential impacts to cost of care (if known), whether there are related existing Anthem, AIM or MCG documents, regulatory information, and relevant specialty society and governmental organization information. While OMPTA does not assign more weight to any one of the factors identified above, when determining to recommend a topic to MPTAC for consideration, patient safety concerns are the primary focus of the process.

In evaluating the medical necessity or investigational status of new or existing services and/or procedures the MPTAC may consider, among other things, the following factors:



- Scientific data supporting the service or procedure;
- Professional Associations or independent technology evaluation programs supporting the service or procedure;
- Electronic literature searches supporting the service or procedure;
- Effectiveness and Member Safety Related to Procedure;
- The standard of care in the medical/behavioral health community;
- Detailed input, especially input supported by distinctive peer reviewed medical literature.

All factors are weighted and considered equally. All factors may not be present for each specific service; thus, the weighting would be based on the specific service or treatment being considered.

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

The process and criteria that MCG uses in the development of its guidelines can be found in Exhibit A. The sources and processes that MPTAC uses to create and review medical policies and clinical guidelines can be found in Anthem medical policy ADMIN.00001 Medical Policy Formation:  
[https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp\\_pw\\_a044135.html](https://www.anthem.com/dam/medpolicies/abcbs/active/policies/mp_pw_a044135.html).

In determining medical policy and clinical UM guidelines for services and procedures, MPTAC considers the factors noted above in conjunction with committee members' own clinical judgment informed by their education and experience.

**Scientific Data:** MPTAC will consider current scientific data, clinical thinking and medical evidence that is peer-reviewed, published in English in a journal Indexed in the National Library of Medicine's PubMed database and uses reasonable rigorous scientific methodology. MPTAC does not take into consideration information such as promotional materials, product dossiers, cost effectiveness studies, white papers, review articles, abstracts, posters or presentations from medical meetings. These materials may not be subject to the same requirements as the beforementioned data and include biases not fully challenged as under the scientific method.

MPTAC reviews persuasive scientific data to determine if the studies provide clinical support to recognize the service or procedure through the creation of objective, clinically based medical policy or clinical UM guidelines. MPTAC does not require a specific level of support for the service or procedure or publication in a specific journal, except as noted above. The scientific data will be considered in light of the committee's clinical judgment to determine whether the service or procedure has a material and proven net health beneficial outcome.

**Professional Associations or Independent Technology Evaluations Programs:** MPTAC will consider the support for a specific service or procedure through publications from professional associations and independent technology evaluation programs. The materials may be published by the following:

- Technology assessment entities;
- Appropriate government regulatory bodies; and



- Authoritative medical specialty societies and associations (e.g., American Medical Association).

MPTAC considers information from the sources above to be potentially less biased and more likely subject to the rigors of the scientific method. The materials may be persuasive and can be objectively considered by committee members in determining whether the appropriate amount of research has been performed and documented to support a medical necessity determination. In reviewing such materials, while the source may be persuasive, MPTAC will objectively consider the materials in conjunction with their clinical judgment to make the overall determination. Thus, a specific quantitative evidentiary standard is not used or expected when reviewing the materials and making clinical medical necessity determinations.

**Effectiveness and Member Safety Related to Procedure:** In general, regulatory bodies, such as the Food and Drug Administration (FDA) will opine on the safety of medical devices and other products potentially used by members after undergoing the FDA's review process. The published safety recommendation is a factor in the development of medical policy and clinical UM guidelines. However, in the event safety indications are not published by a regulatory body or a professional association, Anthem will consider other evidence to review the effectiveness of a new/existing procedure as well as member safety to determine whether a medical policy or clinical UM guideline is necessary. The source materials for such factor includes, specific to the procedure at issue, clinical studies (and the study's methodology) available on the procedure since its introduction. MPTAC will consider whether the procedure has a level of effectiveness to outweigh any member safety concerns evidenced by known and documented side effects at the time of publication.

**Electronic Literature:** The results of electronic literature searches are also a factor. MPTAC may consider study methodology, including but not limited to features such as randomization, blinding, clinically appropriate follow-up periods, and use of validated and objective measurements tools. MPTAC will also consider whether studies provide credible scientific evidence which permits reasonable conclusions regarding net health outcomes and clinical utility and appropriate comparisons to established alternatives.

**Standard of Care:** MPTAC may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation. The supporting documentation to demonstrate a particular service or procedure has become the standard of care may come from publications referenced above and further supported by committee members' clinical judgment. Input from current practitioners in the medical and behavioral health community may provide further evidence of the standard of care and support (or lack thereof) of the medical necessity of the service or procedure.

As noted in the Medical Policy Formation process, cited previously, the above factors, sources, and standards are used by OMPTA and the MPTAC to develop medical policy and clinical UM guidelines for the medical necessity of services and procedures. MPTAC meets at least three times per year, and reviews the following:

- Agenda items (e.g., new procedures or services) brought to and researched by OMPTA staff;



- Every MCG guideline at least annually to determine whether to continue to use the guideline and/or whether any Anthem-specific modifications should be proposed for review and approval by the MPTAC;
- All other existing medical policies and clinical UM guidelines at least annually to identify new published peer reviewed medical studies or other evidence from authoritative sources that may influence the decision-making process of the MPTAC regarding their determination as to the medical necessity or investigational nature of the services under their consideration.

**Detailed Peer Input:** Expert clinical opinion may be obtained from relevant specialists from within and external to Anthem when appropriate. The process allows MPTAC access to the expertise of wide variety of specialists and subspecialists from across the United States. The input will be considered based on the credentials of the individual providing the information, and those with potential biases (e.g., paid consultants for a particular service) are considered accordingly.

Medical policies/clinical UM guidelines may contain fail first requirements. When a medical policy/clinical UM guideline is created or reviewed, Anthem primarily relies upon the inclusion criteria that was utilized to test the treatment's efficacy when determining whether to apply a fail first requirement. For example, if a service was tested and proven successful only on individuals over a certain age who had failed a different treatment for the condition, then that will be relied upon when determining when a service is medically necessary. MCG utilizes similar criteria in creating its medical policies.

MPTAC decisions on the medical necessity or investigational status of services and procedures are made by a majority vote of the MPTAC voting members present. Following MPTAC review and approval, Anthem medical policies and clinical UM guidelines are published to internal and external Anthem websites and implemented for use by the local markets based on their local requirements.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits.?

Yes, Anthem uses the same processes, strategies, evidentiary standards and other factors when developing and/or approving medical policies, clinical UM guidelines, and deciding whether to apply a fail first requirement for MH/SUD and medical/surgical services.

MPTAC includes committee members with expertise in behavioral health to ensure that any decisions on medical policy and clinical guidelines reflect the standard of care for members with behavioral health conditions. Anthem does not apply these processes, strategies, and evidentiary standards more stringently to MH/SUD benefits than medical/surgical benefits.

Since 2018, Anthem has adopted 89 new medical policies/clinical UM guidelines. All of these were medical/surgical except for the followings, which apply to both medical/surgical and MH/SUD.



- LAB.00044 Saliva-based Testing to Determine Drug-Metabolizer Status
- LAB.00046 Testing for Biochemical Markers for Alzheimer's Disease
- LAB.00048 Pain Management Biomarker Analysis
- MED.00133 Ingestion Event Monitors
- MED.00138 Wearable Devices for Stress Relief and Management
- SURG.00158 Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain

Of the 89 total new medical policies/clinical UM guidelines, only 5 apply a fail first requirement, none of which address HM/SUD conditions

Anthem medical policies and clinical UM guidelines are all available publicly at: <https://www.anthem.com/provider/policies/clinical-guidelines/updates/>. Clinical UM Guidelines are applied separately in each state and is a market determination (see Prior Authorization NQTL Comparative Analysis for additional discussion on this process). Overall, Anthem has 477 total medical policies (248) and clinical UM guidelines (229). While some medical policies and clinical UM guidelines may apply to both M/S and MH/SUD services, Anthem has only internally developed 3 clinical UM guidelines specific to behavioral health, but has adopted additional guidelines from an independent third party, MCG.

For MH/SUD services specifically, Anthem does not apply any fail first requirements to inpatient stays, including residential treatment center, partial hospitalization, intensive outpatient or routine outpatient services.<sup>1</sup> Transcranial Magnetic Stimulation (MCG policy), which is FDA approved for severe treatment resistant depression in adults, is one MH/SUD service for which there is a fail first requirement. Clinical criteria and the FDA approved indication for TMS is for treatment of Major Depressive Disorder in adult patients who have failed to receive satisfactory improvement from prior antidepressant medication. Electroconvulsive Shock Therapy (ECT) (MCG policy) is an example of a service where a member may be required to fail drug therapy, but would be eligible for the service without failing that therapy if certain conditions are met (e.g., suicidal). Other than those examples, there are no other fail first requirements on MH/SUD services. However, there are many medical/surgical services for which there may be a fail first requirement.

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. Anthem follows the same process for establishing and reviewing medical/surgical and MH/SUD medical policies and clinical UM guidelines. The process for adopting medical policies and clinical UM guidelines starts with a consideration of factors all deeply rooted in the clinical information available for such service. The multi-disciplinary group of professionals with both medical/surgical and mental health/substance use disorder experience review the clinical information available, regulatory approvals, consult with outside experts in the relevant specialty, as needed, and utilize their clinical judgment to make determinations about medical policy and clinical UM guidelines.

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<sup>1</sup> This statement applies to Anthem's medical policies and clinical UM guidelines as well as MCG. It might not apply in states in which Anthem is required to use ASAM or other criteria.



For MH/SUD services, the committee has elected to adopt criteria and guidelines established by an independent, third-party organization, MCG and has only internally developed a small fraction of the amount of guidelines for MH/SUD in contrast to those applicable to M/S services. The MCG Guidelines are subject to intense peer review and regulatory scrutiny, and are also used by many provider organizations as the preferred resource to determine medical necessity for both M/S and MH/SUD services.

With respect to fail first requirements, there are very few services for which a fail first requirement applies for MH/SUD services and the rationale for why a fail first requirement exists is consistent with the medical literature and the medical community/professional organizations. Therefore, Anthem's medical policy process treats MH/SUD services no less favorably than medical/surgical services.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and



underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



## NQTL SELF COMPLIANCE TOOL

**Overview:** Anthem's fully insured policies and the plans that it administers on behalf of self-funded employers utilize a provider network established by Anthem. Although Anthem has multiple networks, the same processes described below are used in the formation and modification of each network arrangement.

### 1. Identify the NQTL: Network Adequacy – CA, CO, CT, GA, IN, KY, ME, MO, NV, NY, OH, VA, WI

This network adequacy NQTL analysis describes the annual assessment process for in-network practitioner access and availability to members, and how the measurements are used to determine network alterations. It further describes how Anthem's processes, strategies, evidentiary standards, and other factors for network development comply with the NQTL requirements under MHPAEA.

The NQTL applies to all medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) providers across all network benefit classifications subject to objective access and availability standards established by the NCQA, CMS, and state law.

#### Definitions:

**CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey:** A standardized annual survey that is used to assess the Commercial and Private Exchange patients' experiences with getting healthcare and to improve quality of care. The survey is developed and maintained by the AHRQ (Agency for Healthcare Research and Quality), a government agency.

**National Committee for Quality Assurance (NCQA):** The NCQA is a non-profit organization promulgating health plan accreditation standards and quality measures for the health industry. The NCQA also performs accreditation reviews of health plans relied on by the industry and regulators for evidence of compliance with standards including credentialing, utilization management, and network adequacy through access and availability to care measurements.

**Network Adequacy:** A determination of geographic and appointment access performance, realistic for the community and the delivery system. Annual quantitative assessment of membership with availability to in-network practitioners by type, within the established mileage or minutes of their residence and the access to timely appointments for those practitioners. Accreditation data is not assessed at a level of group, product or treatment criteria.

**Practitioner Accessibility:** The extent to which members obtain timely appointments and after hours contact with medical and behavioral health care practitioners.

**Practitioner Availability:** The extent to which members have adequate numbers and types of primary care, specialty care, and behavioral healthcare practitioner available to meet their healthcare needs.

### 2. Identify the factors considered in the design of the NQTL:

#### Factors:

- Is there an NCQA accreditation standard that applies for practitioner availability?





- a. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network geo availability requirements for M/S and MH/SUD providers.
- b. Does the state have a specific practitioner availability requirement?
  - i. If yes, the state law will supplant the base policy requirements predicated on the NCQA standards.
  - ii. If no, the base policy requirement predicated on the NCQA standard will apply.
- Is there an NCQA accreditation standard that applies for practitioner accessibility?
  - a. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network appointment accessibility requirements for M/S and MH.SUD providers.
  - b. Does the state have a specific practitioner accessibility requirement?
    - i. If yes, the state law will supplant the base policy requirements predicated on the NCQA standards.
    - ii. If no, the base policy requirement predicated on the NCQA standard will apply.
- What are the results of the various member surveys?
- Does Anthem have any internal member complaints on provider access or availability?

NCQA accreditation standards are the primary weighted factor in determining appropriate access and availability measurement guidelines unless a state or federal law provides a more stringent standard.

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Sources:

- NCQA Accreditation Standards for Network Management (NET1-Availability of Practitioners and NET2-Accessibility of Services).
- State statute or regulation directive for availability or accessibility standards. State statutes are referenced below.
- Quest Analytics Suite™ geo access reports
- Member surveys including:
  - a. Consumer Assessment of Healthcare Providers and Systems Survey
  - b. Enrollee Experience Survey
  - c. Behavioral Health Member Experience Survey
- Practitioner Level Access Study
- Member complaints

State statues outside of base policy metrics.	
California	Title 10, California Code of Regulations, Title 28, California Code of Regulations
Colorado	Title 10, Article 16, Part 7 Network availability Colorado Regulation 4-2-53. Network Adequacy Standards
Maine	Revised Statue Title 24-A (non-descriptive) and Bureau of Insurance Rule Chapter 850
Missouri	Title 20 / Chapter 7 / 20 CSR 400-7.095 MO Reg: 354.603, 354.602
Nevada	Nevada Administrative Code <b>Nevada Regulation</b> NAC 695C.160.
Virginia	Title 38 Virginia regulation 12 VAC 5-408-260, 12 VAC 5-408-270, 12 VAC 5-408-280



Anthem is committed to a standardized process to assure that members can obtain access to practitioners for medical and behavioral health services. The processes used to evaluate Provider Availability and Provider Accessibility are the two primary methods in determining network adequacy.

### **Anthem Practitioner Availability Process**

Anthem utilizes standard measures to annually assess members' availability to sufficient numbers and types of practitioners providing primary care, behavioral healthcare, and specialty care. The Practitioner Availability Process is reviewed annually to assess for necessary revisions as a result of changes to NCQA accreditation standards, state laws, and results of member surveys. The standards ultimately determine the input to measure and evaluate the applicable networks for numbers and types of all contracted practitioners who practice primary care, specialty care, and behavioral healthcare. NCQA standards form the basis for base policy measurements and guidelines, but state variations are included to the extent a state law diverges from the accreditation standard.

The NCQA and applicable state laws define required practitioner availability guidelines and standards based on geographic availability and a membership ratio. The geographic measurement is typically the number of providers in a specific subset compared with the number of members in the same zip code for a specified amount of miles. For example, the NCQA standard for urban settings is two (2) primary care practitioners within 5 miles as noted in the graphic below. Anthem annually measures compliance with the geographic guideline standards through Quest Analytics Suite™ software. The results determine whether the current network meets requirements for M/S and MH/SUD providers, or if additional providers need to be added to the network to meet availability requirements.

In addition, Anthem looks at the ratio of members to a specific subset of providers in each network. The ratio goal formula is the same calculation for all M/S and MH/SUD providers. The actual quantitative goal may change based on the area, membership amounts, and number of available providers in the area, but it is designed to ensure members have sufficient choices of providers. Ratios are calculated annually for each specific provider type to determine if a network satisfies adequacy requirements.

Anthem also considers other factors in the monitoring of its provider availability. First, reviews of open practice rates confirm new patient selection and availability. Anthem has a standard goal, 90%, for open practices for each primary care practice type and behavioral health practitioners per network. Anthem also considers member responses to multiple satisfaction, cultural surveys, and clinical complaints. The results are compared with the ratio and open practice results to determine if additional provider types are needed for a particular geographic area. Behavioral healthcare survey responses are specifically considered, and matched to Anthem specific goals.

### **Anthem Practitioner Accessibility Process**

Anthem also utilizes a standard process to assess members' access to timely appointments for medical and behavioral health care. Through monitoring of fulfillment of accessibility standards, network recruiting and development priorities can be adjusted to ensure adequate providers to serve members. The standard process applies to both M/S and MH/SUD providers.

Anthem uses multiple mechanisms to evaluate networks for access to primary care, specialty care, and behavioral healthcare services. Member surveys (CAHPS, Enrollee Experience Survey, BH Member



Survey), a practitioner level access study (telephonic contacts to provider offices), and a review of member complaints are used to determine whether provider accessibility and wait times meets applicable NCQA standards, CMS, or state law requirements. For example, CMS establishes national goals for Enrollee Experience Survey responses related to urgent care, routine care, and specialty care access. The surveys assess accessibility of both M/S and MH/SUD providers. Responses are compared with the measurements and goals established by the NCQA standards (see below), CMS, or state law requirements, if applicable, to determine if additional network capacity is required.

Both the Practitioner Availability and Practitioner Accessibility Processes are used to determine if provider networks as designed are adequate and meet the membership needs.

Geographic Standards *			
Provider Type	Urban	Suburban	Rural
Primary Care Physician	2 practitioners within 5 miles	2 practitioners within 12 miles	2 practitioners within 30 miles
Specialists	All members – 1 within 30 miles		
MH practitioner	2 MLT within 10 miles	2 MLT within 25 miles	2 MLT within 60 miles
Source: Accreditation standard guidance. * Some states use the regulatory metro format as mileage or minutes variation, i.e., CO, NV and NH. Others use a common mileage, as CA and ME.			

Appointment Wait Times *		
Provider Type	Wait Times for Urgent Appointments **	Wait Times for Routine Appointments
Primary Care Physician	Within 24 hours	Within 10 business days - routine Within 30 calendar days – routine follow-up
Specialists	Within 24 hours	Within 30 calendar days – routine
MH practitioner	Within 48 hours	Within 10 business days - routine Within 30 calendar days – routine follow-up
Source: Accreditation standard guidance. * Some states use regulatory variations, i.e., CA, CO, CT, MO, NH and VA. ** NCQA allows the organization to determine urgent appointment wait time standard for PCP, however, requires BH urgent at 48 hours.		

- Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?



Yes. As noted above, Anthem uses standard, objective criteria established by the NCQA and various state laws, as applicable, to determine the measurements for compliance with network adequacy availability and access requirements. Anthem uses member survey results and compares with the NCQA and state law criteria analysis to perform a comprehensive review of their networks (M/S and MH/SUD providers included) to determine if the networks are meeting member expectations.

The comparative analysis for each state demonstrates the Anthem Provider Availability and Provider Accessibility policies achieve parity in operation. Upon review, the network of MH/SUD practitioners generally meet or exceed the compliance standards for network adequacy as measured by Quest Analytics Suite™ for MH/SUD practitioners. Additionally, when compared with M/S provider compliance, the MH/SUD providers in almost every instance meet or exceed the goal percentage satisfaction of M/S providers. For example, the Virginia HMO network satisfies the psychiatrist geographic measurements for urban and suburban setting 100% of the time. The comparable family medicine practitioners satisfy the same 100% and 99% for urban and suburban settings. Psychiatrists satisfy the Quest Analytics Suite™ requirements for Rural areas (98%), and trail family medicine providers by only 1%. In California, the network availability satisfies the Quest Analytics Suite™ standards at 100% for virtually all providers. Also in California, the behavioral health providers meet and exceed accreditation goals for appointment access and generally perform better than their medical/surgical counterparts. Therefore, the data comparison demonstrates parity in operation for network adequacy requirements.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. Practitioner Availability and Accessibility processes are assessed annually based on objective criteria developed by the NCQA for accreditation, CMS, and state law. These standards dictate requirements for M/S and MH/SUD providers. Anthem internal metrics for other factors such as provider open practices are applied uniformly to M/S and MH/SUD. The standard process and measurements used to evaluate networks results in both M/S and MH/SUD meeting or exceeding standards in almost all measurements, and MH/SUD meeting or exceeding M/S providers in almost every category for each state. When compared, the data demonstrates the network geographic access and appointment availability are very similar with MH/SUD often outperforming M/S providers.

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## CONTRACTING NETWORK ADEQUACY STANDARDS \*

BH GEOGRAPHIC AVAILABILITY RESULTS		Behavioral Health	BH Non-life threatening Emergent 6 hrs. (reg/ accred)	BH Urgent 24 hrs. (reg/parity/ accred)	BH Routine, Initial 10 bus days (accred)
STATE	NETK	PRACTITIONER	202		
GA	HMO	Psychiatrist	100%	100%	98%
		Psychologist	100%	100%	94%
		Masters Level Therapist	100%	100%	99%
		-	-	-	-
		-	-	-	-
		-	-	-	-
GA	PPO	Psychiatrist	100%	100%	98%
		Psychologist	100%	100%	94%
		Masters Level Therapist	100%	100%	99%
		-	-	-	-
		-	-	-	-
		-	-	-	-
Exchange GA	HMO	Psychiatrist	100%	100%	98%
		Psychologist	100%	100%	94%
		Masters Level Therapist	100%	100%	99%
		-	-	-	-
		-	-	-	-
		-	-	-	-

Accreditation & Reg BH Goal: 90%

* <b>Data Clarification / Disclaimer - Do not remove</b>			
Data is not assessed at a level of specific treatment criteria.			

Office level appointment access to the universe of network practitioners with a random sampling in each type.

Assessment of members who can get an appointment within the desired timeframe. No correlation with limited treatment o

Results are not group or benefit plan specific.

BH Routine, Regular 10 bus days  (parity)	BH Routine, Follow-up (from today's appt.) 30 cal days  (parity/ accred)	MEDICAL GEOGRAPHIC AVAILAILBITY RESULTS		Medical	Urgent 24 hrs.  (reg/ parity/ accred)
2		STATE	NETK	PRACTITIONER	
94%	98%	GA	H M O	Family Medicine	100%
100%	100%			Internal Medicine	100%
99%	100%			Pediatrics	100%
-	-			Ortho	-
-	-			OB/Gyn	-
-	-			Onc/Hemo	-
94%	98%	GA	P P O	Family Medicine	100%
100%	100%			Internal Medicine	100%
99%	100%			Pediatrics	100%
-	-			Ortho	-
-	-			OB/Gyn	-
-	-			Onc/Hemo	-
94%	98%	Exchange  GA	H M O	Family Medicine	100%
100%	100%			Internal Medicine	100%
99%	100%			Pediatrics	100%
-	-			Ortho	-
-	-			OB/Gyn	-
-	-			Onc/Hemo	-

Accreditation & Reg PCP & Spec Goal: 90%


or services.

<div>Routine, Check-up 10 bus days</div> <div>(reg/ parity/ accred)</div>	<div>Routine, Follow-up (from today's visit) 30 cal days</div> <div>(parity)</div>	<div>Urgent 24 hrs.</div> <div>(reg/ parity/ accred SPC)</div>	<div>Routine 30 cal days</div> <div>(parity /accred Q. SPC)</div>
2022		2022	
99%	100%	-	-
99%	100%	-	-
100%	100%	-	-
-	-	100%	100%
-	-	99%	99%
-	-	100%	98%
99%	100%	-	-
99%	100%	-	-
100%	100%	-	-
-	-	100%	100%
-	-	99%	99%
-	-	100%	98%
99%	100%	-	-
99%	100%	-	-
100%	100%	-	-
-	-	100%	100%
-	-	99%	99%
-	-	100%	98%




## NQTL SELF COMPLIANCE TOOL ( *\*only applicable for Commercial LOB* )

1. Identify the NQTL: **Nonparticipating Provider Reimbursement – Georgia**
2. Identify the factors considered in the design of the NQTL:
  - Is there a state mandate that dictates how a service should be reimbursed if the provider is nonparticipating
  - What are participating providers paid for the same service
  - Is the provider a professional provider, facility or an emergency provider
  - Overall cost-of-care to keep premium reasonable
3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

In general, the rates we use to price or pay for services rendered by providers that do not participate in our networks are based on rates that are accepted by providers that do participate in Anthem networks. Anthem's methodology for pricing, except where a state mandate dictates another rating methodology (states that do so typically do so with respect to Emergency (ER and/or ambulance services) or where a nonparticipating provider is providing services in a network facility), is as follows:

  - I. Professional Claims

We apply a fee schedule that applies 85%-100% of the rates contains rates that have been accepted by providers who participate in our networks in that market and have not individually negotiated rates with some exceptions.

    - MH/SUD applies 100% of the rates that have been accepted by providers who participate in our networks.
      - Exception would be the E&M codes because the same fee schedule is utilized for psychiatrists and medical/surgical providers. Therefore, non-network providers that provide MS/SUD services will receive anywhere from 85% -100% of the rate used for participating providers.
    - In New York, payment is based on a percentage of National Medicare or, for large groups (50 or more employees), a methodology chosen by the large group employer as permitted by a State mandate.
  - II. Non Hospital Facility Claims
    - A. ASC, Dialysis, HHC, Hospice, Mental Health/Substance Abuse Facilities and SNF\*

We apply a rate that is based on 85%-100% of the median rates applicable to our participating providers in that state, subject to limited exceptions.

      - Behavioral Health is based on 100% of the median rates applicable to our participating providers in that state.
      - In New York, pricing is based on the average county rate negotiated with participating providers.
    - B. Other Non-Hospital Facility Claims billed on UB04





We apply a percent off of charge methodology that reflects the aggregate participating provider rates for the PPO network, except New York. In New York, pricing is based on the average county rate negotiated with participating providers.

III. Hospital Claims

We apply 15% mark up above the individual hospitals' own reported cost. In New York, pricing is based on the average county rate negotiated with participating providers.

*\* This non-par facility pricing only applies when services are billed on a UB-04/Facility Claim form.*

- IV. States Outside of Anthem's 14 State Footprint. Anthem sells Blue Cross or Blue Cross and Blue Shield plans in California, Nevada, Colorado, Wisconsin, Missouri, Kentucky, Indiana, Ohio, Georgia, Virginia, New York, Connecticut, New Hampshire and Maine. If nonparticipating provider claims are received from states other than those 14, Anthem prices the claim using either the local Blue Cross and/or Blue Shield plan's pricing or our own.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

As noted above, Anthem's practice is to always pay non-network MH/SUD providers using the rating methodology specified above (E&M codes pay at 85%-100% of network providers, all other CPT codes pay at 100%). For medical/surgical providers, depending on the CPT code, they may be paid anywhere from 85-100% of that rate. For E&M codes that are in common between MH/SUD providers and medical/surgical providers, the comparative analysis below shows we pay the same amount to both types of providers.

Comparative Analysis

GAP5 334A									
GEORGIA - Atlanta	99202	99203	99204	99205	99211	99212	99213	99214	99215
Family Prac	\$80.33	\$114.21	\$175.75	\$222.51	\$22.04	\$44.02	\$73.30	\$106.66	\$143.66
Psych	\$80.33	\$114.21	\$175.75	\$222.51	\$22.04	\$44.02	\$73.30	\$106.66	\$143.66
GAP5 335A									
GEORGIA - outside Atlanta	99202	99203	99204	99205	99211	99212	99213	99214	99215
Family Prac	\$85.23	\$120.67	\$184.42	\$233.04	\$23.89	\$47.06	\$77.57	\$112.51	\$151.12
Psych	\$85.23	\$120.67	\$184.42	\$233.04	\$23.89	\$47.06	\$77.57	\$112.51	\$151.12

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. Anthem always reimburses non-network providers that provide MH/SUD benefits at 100% of the rate used for participating providers. Exception would be for E&M codes where non-network providers that provide MH/SUD services will receive anywhere from 85% -100% of the rate used for participating providers, just like medical/surgical services. Non-network providers



that provide medical/surgical services will receive anywhere from 85% -100% of the rate used for participating providers. Thus, Anthem's methodology is equal to or more generous to MH/SUD providers, depending on the services being billed.



## NQTL SELF COMPLIANCE TOOL PRIOR AUTHORIZATION

1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply.

Anthem's fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary. The plan document example is attached as **Exhibit 1** and details how the prior authorization process works for members. This analysis explains when Anthem performs a prior authorization review and how Anthem's processes, strategies, evidentiary standards and other factors for prior authorization review comply with the NQTL requirements under MHPAEA.

If a self-funded group utilizes Anthem's standard prior authorization list, this NQTL applies to that group plan as well, although the plan language may differ.

The Prior Authorization NQTL applies to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) services as identified on the prior authorization list and within the inpatient in-network, inpatient out of network, outpatient in-network, and outpatient out of network benefit classifications. Anthem has identified the services requiring prior authorization and their respective classifications below.

Members can locate prior authorization lists online at [anthem.com](https://anthem.com), or can call member services on the number referenced on their identification card. Additionally, the prior authorization process is detailed in the member's benefit booklet/evidence of coverage materials. **Exhibit 1** represents Anthem's standard fully insured language providing members the information needed on when and how to get approval for benefits, including an overview of the prior authorization review process.

Providers can locate prior authorization lists online at [anthem.com](https://anthem.com), and can check prior authorization requirements by CPT codes through the online portal. Any changes to the prior authorization list or process are also communicated to providers through monthly provider newsletter communications. The utilization management program, which includes prior authorization review, is also thoroughly outlined in each provider manual. The provider manual is accessible online at [anthem.com](https://anthem.com). An example of these materials are included as **Exhibit 2**.

Anthem has provided the list that reflects the standard services that require prior authorization as of January 1, 2023 and is displayed on [www.anthem.com](https://www.anthem.com). (See, **Exhibit 3**)

**Exhibit 4** is a listing of the clinical UM guidelines adopted by Anthem and in effect as of January 1, 2023.

**Exhibit 5** illustrates the ROI for the associated policy based on claims data from Q4 2021 – Q3 2022 (report run on April 17, 2023 by Business Info Consultant Sr).

Anthem is providing some clarifying definitions regarding specific terms used in this comparative analysis.

**Prior Authorization** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date, including but not limited to pre-admission review, pretreatment review, Utilization Review and Case Management.

**Medical Policy** - Anthem medical policies are used by all plans and lines of business (unless an applicable Federal law, state law, or contract language states otherwise) for medical necessity reviews. They are developed to address experimental or investigational technologies and services where there is a significant concern regarding member safety.



**Clinical Utilization Management Guideline** - Clinical utilization management guidelines are not always used by all plans or lines of business, but are available for adoption to review the medical necessity of services related to the guideline when the Plan performs a utilization review for the subject. They are developed to address medical necessity criteria for technologies/services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay place of service, and level of care.

**Return on Investment** – ROI is a factor used in the development of the prior authorization list. The analysis compares the medical cost savings with the cost of administering the prior authorization program. The analysis is based on historical medical management data for each procedure code, which are ultimately attributed to each Medical Policy and Clinical Utilization Management Guideline.

**Medical Policy & Technology Assessment Committee (MPTAC)** - The Medical Policy & Technology Assessment Committee (MPTAC) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. The MPTAC consists of physicians external to Elevance Health who are in active academic and community practice, as well as internal Elevance Health medical directors. MPTAC created the medical necessity criteria within medical policy and clinical utilization management guidelines used by medical directors to determine the medical necessity of services.

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits.:

- Applicable Medical Policy or Adoption of a Clinical Utilization Management Guideline over the particular service;
  - Appropriateness of care;
  - Member Safety;
  - Member/Provider Abrasion;
  - High Cost of Services;
- Competitor Policies (inpatient only);
- State laws, regulations, or other federal/state mandates (e.g., Medicaid contract requirements)

**Factor Weighting:** A state or federal mandate will ultimately control whether a service is included or deleted from the prior authorization, as Anthem will comply with the mandate despite the consideration of other factors.

If a mandate is not applicable, the presence of a medical policy is weighted over the other factors. If a medical policy or clinical utilization management guideline is adopted by the local plan, the services subject to the MP or CUMG may be subject to prior authorization except where the service is considered investigational for all conditions. Member safety also outweighs the consideration of ROI or cost of care concerns during the determination of whether to adopt a CUMG.

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.:



### ***General Overview:***

Anthem conducts utilization review on services for which it has a subject matter specific medical policy or clinical UM guideline (including third-party guidelines)) and uses MCG criteria, which include goal length of stay criteria, unless a state law requires the usage of an alternative criteria (e.g., ASAM, LOCUS/CALOCUS). Anthem also has an Administrative Medical Policy, ADMIN.00006, that provides a framework for review of services for medical necessity determinations in certain circumstances where Anthem does not have a subject matter specific medical policy or clinical UM guideline (including third-party guidelines), such as when a service is new and Anthem has not yet decided whether to develop policy or a guideline on point and a request for precertification has been received from a provider even though Anthem doesn't require prior authorization. Anthem uses MCG criteria, including those that pertain to inpatient lengths of stay, unless state law requires usage of an alternative criteria. The Medical Policy & Technology Assessment Committee (MPTAC) is the body that both approves the medical policies and clinical UM guidelines (and third-party guidelines, including the usage of MCG criteria). MPTAC includes a provider that specializes in behavioral health as a committee member in addition to providers in other medical and surgical specialties.

Anthem reviews its prior authorization list at least semi-annually to determine whether to add or remove a service from the list. The initiation of a determination whether to add or remove a service from the preauthorization list begins with an inquiry received from a source such as:

- a. Post Medical Policy & Technology Assessment (MPTAC) meeting (this includes any changes to medical policy or clinical UM guidelines made by MPTAC);
- b. Clinical Criteria Review Team (CCRT) request;
- c. New diagnosis and procedure codes released by the AMA and CMS;
- d. Health Plan request to initiate rule change for their line of business (e.g., specific state commercial or Medicaid line of business).
- e. State or federal regulatory guidance.

Whether a request is made or simply following the quarterly MPTAC meeting, the determination of whether prior authorization will be required is based on the following analysis for inpatient and outpatient M/S and MH/SUD services.

### ***Inpatient Preauthorization:***

Anthem requires that all inpatient stays be preauthorized, whether for medical/surgical services or mental health/substance abuse services.

Inpatient services include elective or emergency hospital admissions, transplant services, maternity stays past the 48-96 hours or a newborn staying past the mother's discharge date, skilled nursing facilities, long term care facilities (LTAC), residential treatment centers. Many surgical services on Anthem's standard prior authorization list could be done in an inpatient or outpatient facility setting.

Application of factors for Inpatient Prior Authorization Determination:

- **Provider/Member Abrasion** – Provider/Member abrasion is a factor considered for the determination of requiring prior authorization for inpatient services. It is helpful to members to have a decision before undertaking a procedure and potentially subjecting members and providers to financial responsibility if such services, normally expensive, were reviewed retrospectively for medical necessity. The abrasion factor considers whether a member or provider would likely submit a grievance or complaint, or be placed in financial hardship if the service is not pre-approved and later denied for lack of medical necessity. The abrasion factor applies equally to medical/surgical and mental health/substance use disorder services.
- **Competitor Plans** – While lesser considered than other factors, Anthem does consider the manner in which competitors subject services to prior authorization. Industry standards



typically subject inpatient services to prior authorization requirements for medical/surgical and mental health/substance use disorder services.

- **Sources:** Review of competitor plans filed in other states or available online.
- **Medical Policy & Clinical UM Guidelines** – Inpatient procedures are subject to medical policies and clinical UM Guidelines. The services have been reviewed and criteria established based on peer reviewed information, and the member is required to satisfy the criteria before a service is ultimately approved.
- **State laws, federal law, program contracts** – These mandates may determine the criteria ultimately required for prior authorization, and some inpatient services may be subject to specific mandates directing when prior authorization can be performed. If these are in place, they will be adhered to for medical/surgical and mental health/substance use disorder services.

### ***Outpatient Preauthorization:***

Whether an outpatient M/S or MH/SUD service requires prior authorization is generally based on whether the service is subject to a medical policy or the plan has adopted a clinical utilization management guideline. Medical Policies and Clinical UM Guidelines are developed by the Medical Policy and Technology Assessment Committee (MPTAC) according to the Medical Policy Formation process outlined in ADMIN.00001 Medical Policy Formation. This process is also discussed further in Anthem's Medical Policy and Fail First NQTL comparative analysis. MPTAC does not play any role in determining whether such service, Medical Policy or Clinical UM Guidelines, and the procedure codes under such policies and guidelines, will require prior authorization.

Clinical Utilization Management Guidelines developed by MPTAC are subject to review and adoption by the Clinical Criteria Review Team (CCRT). The CCRT contains cross sectional representation of key stakeholders across the enterprise and includes the lead plan medical director, medical directors, health plan directors, reimbursement policy management and both UM and clinical operations team. The CCRT considers the following factors in determining whether to adopt the clinical UM guideline and whether such will require prior authorization:

- **Member Safety** – Member safety is a paramount concern with all procedures, and is a factor in the determination of whether to adopt a clinical utilization management guideline. In considering member safety, the Clinical Criteria Review Team will review the clinical materials (scientific data, clinical studies, government agency analyses/approvals) to determine the risks of such procedures on members. The team may also review subsequent studies on the services and treatment following regulatory approval to determine the presence of other risks or side effects. The risks will factor into the criteria's establishment, and also be considered by the Clinical Criteria Review Team in whether such medical/surgical or mental health/substance use disorder treatment or service should require prior authorization. Ultimately, this factor will be based on the clinical judgment of the personnel on the Clinical Criteria Review Team.
- **Member/Provider Abrasion**- Provider/Member abrasion is a factor considered for the determination of requiring prior authorization for outpatient services. It is helpful to members to have a decision before undertaking a procedure and potentially subjecting members and providers to financial responsibility if such services were reviewed retrospectively and denied for lack of medical necessity. The abrasion factor considers whether a member or provider would likely submit a grievance or complaint, or be placed in financial hardship if the service is not pre-approved and later denied for lack of medical necessity. The abrasion factor applies equally to medical/surgical and mental health/substance use disorder services.
- **Appropriateness of Care** – Medical directors will consider whether or not the services subject to the Medical Policy or Clinical UM Guideline are subject to appropriate levels of care concerns. If so, a particular service may be subjected to prior authorization to ensure a member is receiving care at the



level or form that is justified based on their presenting conditions and treatment history. Anthem will look to regulatory approvals, such as the FDA, to determine what types of conditions the procedure/service is approved to treat and any applicable stipulations on when care should be received.

- **State law, regulation, contractual requirements** – State law, regulations, and contractual requirements (e.g., Medicaid contractual requirements) may stipulate when prior authorization (i.e., medical management) may or may not be used for a particular service. In the event a medical policy or clinical UM guideline is being considered in a respective state, but the applicable service is subject to state mandate requiring or prohibiting prior authorization for such service, the state mandate will be followed for M/S and MH/SUD services, as applicable.
- **High Cost of Services** – For medical/surgical services, Anthem uses a return-on-investment analysis in consideration of the cost of services. The data analysis is performed by Business Analysts on the Finance/HealthCare Analytics team. The source for the analysis consists of:
  - Clinical review costs – The internal costs to Anthem for personnel, equipment, technological systems, system upgrades and programming, and other investments necessary to complete a prior authorization review and determine the medical necessity of requested services against the criteria developed by MPTAC.
  - Case Data – Review of historical claims and medical management case data to determine the costs of the particular services, usage trends, and medical coding for the cases.

The Financial Analytics team will analyze the data to determine the clinical review costs incurred by procedure code that is attributable to the specific medical policy or clinical utilization management guideline. Medical policies or clinical utilization management guidelines realizing savings through a length of stay consideration are not included in the analysis. Additionally, an estimate of the potential savings is projected based on the medical costs associated with each procedure code attributable to the specific medical policy or clinical utilization management guideline. The result is a ratio of the medical cost savings (e.g., savings resulting from non-payment for services deemed not medically necessary) over the clinical review costs (e.g., costs associated with performing the review). For clarity and ease of review, the team subtracts one from the quotient for those codes, clinical UM guidelines, and medical policies with a higher cost than savings. These particular codes, clinical UM guidelines and medical policies, will be referenced as a negative net ROI. If savings outweighs the clinical review costs, the ratio will be presented as a positive for the Clinical Criteria Review Team consideration.

The data is ultimately presented to the Clinical Criteria Review Team for consideration in the determination of whether the Medical Policy or Clinical Utilization Management Guideline, and the underlying procedure codes, should require prior authorization. Cost is one factor in the overall analysis, and will be weighed less than the other factors of appropriateness of care or member safety. The evidentiary standard for cost is a 5:1 ROI (savings to cost). If the particular Medical Policy, Clinical Utilization Management Guideline (and the underlying procedure codes) has an ROI 5:1 or above, the finance team will provide a recommendation to the Clinical Criteria Review Team for inclusion on the prior authorization list.

The calculations above are continuously prepared and updated throughout the year and are reported on a quarterly basis.

Mental Health/Substance Use Disorder Services - Inpatient		
Service	Factor	Source/Standard/Description
Inpatient Admissions (All inpatient admissions and RTC)	Member/Provider Abrasion, Competitor Policies	Inpatient admissions for all medical surgical services are required to be prior authorized, just like inpatient admissions,



		including residential treatment center admission, for MH/SUD services.
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Mental Health/Substance Use Disorder Services - Outpatient		
Service	Factor	Source/Standard/Description
Intensive Outpatient (IOP) & Partial Hospitalization (PHP)	MCG Guideline – High Cost Services, Member/Provider Abrasion	Anthem utilizes MCG criteria for IOP/PHP. In determining the application of prior authorization, Anthem looks at the average length of stay based on claims data and the average per diem for each service. As a result of the calculations, the service is deemed high cost, which would likely result in member/provider abrasion if services were performed and denied retrospectively for lack of medical necessity.
Transcranial Magnetic Stimulation	Adopted CUMG – Member Safety & Appropriateness of Care	Anthem utilizes MCG criteria for this service. Due to member safety and appropriateness of care concerns, the requests for TMS are reviewed according to FDA approvals to ensure some form of medication treatment has been tried without response before using TMS for treatment of major depressive disorder.
Adaptive Behavioral Treatment (e.g., ABA or applied behavioral analysis)	Adopted CUMG – Appropriateness of Care, Member Abrasion & High cost of services	Anthem has adopted a clinical UM guideline and due to the high cost of services. The ROI analysis was above the 5:1 threshold for consideration, and member abrasion would result if services were provided (typically high volume) and later denied for lack of medical necessity.
Intensive Home Behavioral Therapy	Adopted CUMG- Appropriateness of Care, Member Abrasion & High cost of services	Anthem has adopted a clinical UM guideline due to the high cost of services. The ROI analysis was well above the 5:1 threshold for consideration, and member abrasion would result if services were provided (typically high volume) and later denied for lack of medical necessity.





standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits.?

**Prior Authorization List Development Process Overview:** The following describes the process applied to determine if prior authorization is appropriate or whether an existing prior authorization should be removed. It applies to medical/surgical and mental health/substance use disorder services in the same manner.

Data Analysis is performed using data models established by the Finance team using a similar methodology across all lines of business (LOB), including the cost of prior authorization (e.g., clinical review costs mentioned above). (Data models are based on 24 months of data with a 3 month claim lag.) Reports may be requested from the appropriate Finance team within each LOB being evaluated. The review occurs quarterly following the MPTAC meeting and during the semi-annual review when all clinical guidelines and medical policies are reviewed.

- Determine if clinical criteria or medical policy is present;
- Determine if Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) codes are currently on a post service (relational) edit;
- Determine if CPT/HCPCS codes are considered Not Otherwise Classified (NOC) or Add On codes.

A Business Analyst determines if the savings meets the established Anthem methodology for ROI (CoC ROI or administrative). Ensures full code set is reviewed to evaluate services to be added or removed from requiring prior authorization.

- Clinical UM Guideline or medical policy must be present to add authorization:
  - Criteria created when a new treatment appears on the scene. Judgment made on known or potential risk for harm to the member.
  - Criteria created when treatment is used all of the time in the standard of care and there is a potential for overutilization, fraud, waste and abuse.
- Items considered before adding services to require prior authorization (no one factor weighs more heavily than another):
  - Member impact
  - Provider Abrasion,
  - High cost.

The Business Analyst prepares a summary and recommendation to be presented to the Clinical Criteria Review team (CCRT) to be vetted in preparation for submission for approval.

The CCRT reviews recommendations and agrees to either send for review and approval or may recommend modifications based on other data points (i.e., relational edits, over utilization, PSSCR or sentinel effect).

The CCRT recommendations are submitted to the health plan's Regional Vice President Medical Director for consideration. The RVP Medical Director will consider the recommendation amongst the additional factors noted above, and utilize their clinical judgment in determining if the clinical UM guideline should be adopted and if prior authorization is warranted based on the factors (appropriateness of care, member safety, member/provider abrasion, state mandates) considered. The RVP Medical Director has the ultimate authority to approve the adoption of a clinical UM guideline and the adoption/removal of a service from the prior authorization list. The same process and consideration applies to both M/S and



MH/SUD services.

Once the initiative is approved, the Anthem UM Rule team will assign an Initiative Owner and begin the formal implementation project. The Anthem UM Rule team is the operational team that implements the decision to add/remove a service from the prior authorization to ensure the systems are adjudicating claims properly and appropriate communications have been released regarding any change. The UM Rule Team does not make any clinical judgments as to whether a service should be added or removed.

Anthem will also perform preauthorization for services not on the prior authorization list when such a review is requested by the provider.

The process to add/remove a service from the prior authorization list is the same for MH/SUD and M/S services. Additionally, the factors, sources, and evidentiary standards are applied comparably and no more stringently to MH/SUD services as M/S. Of note, MH/SUD services are not often considered for addition and removal to the prior authorization; thus, the process employed above is normally utilized to consider M/S services.

### **Prior Authorization Penalty Process**

Anthem's fully insured policies do not include a member penalty if prior authorization is not received. However, for medical/surgical services, if an in-network medical/surgical provider fails to obtain a prior authorization for a service on the prior authorization list, the provider's payment may be reduced and the provider is not able to balance bill the member. This reduction does not apply to mental health and substance use disorder services/providers. Thus, Anthem is more generous to network MH/SUD providers than medical/surgical providers.

Our standard approach is to not apply a prior authorization penalty to members if a service is not prior authorized. The exceptions are as follows:

- Connecticut, Georgia, New Hampshire, New York and Virginia - Standard out of Network 50% penalty in Private Exchange plans.
- California Large Group - All standard PPO plans have a prior authorization penalty where member is responsible for an additional \$500 copay if prior authorization is not obtained from Anthem for non-emergency admissions to non-network providers.
- Georgia, Kentucky, Ohio, Virginia, California, Connecticut, New York and Nevada - LG fully insured Private Exchange (PEX) PPO product sold through AON applies a prior authorization penalty for Out of Network services at 50% of eligible expenses up to \$500; penalty does not apply to deductible and OOP maximum.

### **Prior Authorization Process**

The process to add or remove a specific service to the prior authorization list is described above. The actual process for submitting a service for prior authorization review is the same for M/S and MH/SUD services.

Guidelines governing types of service and authorization requirements are clearly defined in the health plan precertification look up tool. Anthem's criteria hierarchy follow state/federal criteria, medical policies, MCG, and then clinical UM Guidelines.

Requests for notification and pre-certification of covered services can either be called into the health plan, called in through the provider call center, faxed to the plan or call center, or the provider may use



the plan's Provider portal, Availity (<https://www.availity.com/>). There are multiple avenues for submission, any of which are acceptable to use. If a provider elects to utilize the fax method, forms are available online through Plan's website to aid in the submission and ensure the provider submits information critical to the service request. The use of forms is optional though and not required.

The Anthem Pre-Certification Team is available to accept requests and respond to issues from 8:30a.m. to 5:00 p.m. (EST), Monday through Friday, excluding holidays. Faxed requests received after 5:00 p.m. (EST) will be processed on the next business day. Our Anthem call center Department is available 24 hours a day, 7 days a week for pre-certification and authorization requests.

At the time of request for notification or pre-certification, the provider is required to submit information regarding the type and quantity of service being requested, as well as, the ICD-10 (diagnosis) codes, CPT (procedure) codes, HCPCS (equipment) codes, requesting provider information, servicing provider, place of service and dates of service. Additionally, clinical information (e.g., medical records) required to support the request is submitted at this time. Anthem provides forms online ([anthem.com](https://www.anthem.com)) that are optional for the provider to use when submitting a prior authorization request. Providers may use multiple avenues to submit a request, so the forms serve as guidelines for the type of information generally required to complete the medical necessity review or determine if such review is applicable to the service request. If the provider elects to use the electronic portal, the following information, at minimum, is required:

- Member Name
- Member ID
- Member DOB
- Payer
- Request Type – Outpatient or Inpatient
- Request "From" and "To" date
- Rendering Provider and (if applicable) Facility NPI or Tax ID
- Service Type
- Place of Service
- Quantity and Quantity Type (e.g., units, visits, months, days)
- Level of Service
- Diagnosis Code(s)
- Procedure Code(s)
- Clinical Documentation Attachments

The MMS (Medical Management Specialist) responds to incoming phone calls, faxed requests, and portal requests, and begins the processing of notification or pre-certification requests in Anthem's UM system utilizing the following procedure:

- Verify the member's eligibility, benefit package and service history utilizing the designated step-by-step procedure.
- Verify the requested service authorization requirement (no pre-certification, pre-certification) by performing a CPT/HCPCS code search in the pre-certification look up tool.
- Verify if the service is a covered benefit in applicable Plan.

If no precertification is required, the provider will be advised no pre-cert is required for the specific code requested. If the service requires pre-certification, and there is no duplicative service on file, the MMS will create a pre-certification request by entering all necessary information into the appropriate



UM system and route the request queue for review by a NMM (Nurse Medical Management).

NMM reviews the cases requiring pre-cert using appropriate clinical hierarchy guidelines. If the request meets criteria guidelines, the NMM will make the determination to approve and complete the request in Anthem's UM system utilizing the designated step-by-step procedure. Written notification will be sent to the member, servicing and requesting provider within required contact timeframes. Verbal notification will also occur at the same time to the servicing provider.

If the request does not meet criteria, the NMM will route the request to the Medical Directors for review.

If the information received is insufficient to make a determination, the NMM will instruct the provider to provide information in support of the request (clinical notes, diagnostic test results, prescriptions, etc.). If it is in the member's best interest to extend the request timeframe, or if the member or provider requests an extension, the NMM will send out a "14 Day Extension" letter no later than the fourteen (14) calendar days from the date of request. The NMM will be responsible for all follow up reviews and/or MDR (Medical Director Review) referrals in reference to these requests.

If the NMM cannot find any criteria guidelines appropriate for use in review of the requested service or if the request is for certain services that require Medical Director Review as per Anthem guidelines, the NMM will route the request to the Medical Director Review queue for review.

If the request is forwarded to the NMM labeled as expedited, the NMM will route to the Medical Director queue as well as notify the Medical Director directly (phone, email, IM) to ensure review within the same business day.

Anthem uses the same processes, strategies, evidentiary standards and other factors for determining whether a service should be added or removed from the prior authorization list for both MH/SUD and medical surgical benefits.

### **In Operation Analysis:**

The data showing the number of prior authorization reviews by line of business (fully insured or ASO, as applicable) conducted in 2022 is attached as Exhibit 6. The data shows prior authorization is not being applied more stringently to MH/SUD services than M/S. In general, with very limited exceptions, a substantially higher number of overall reviews are performed on M/S services than MH/SUD. Although a quantification of the total procedures requiring prior authorization is difficult due to the use of procedure and diagnosis codes, the listing provided above demonstrates overall that a significantly higher number of M/S services require prior authorization. Additionally, the most frequently utilized MH/SUD services (psychotherapy and outpatient therapy) are not subject to prior authorization requirements.

The data also demonstrates the reviews for M/S and MH/SUD services are comparably applied resulting in similar approval and denial figures. While some MH/SUD may be higher, there is nothing to imply the overall process or requirements are being applied more stringently to MH/SUD. In many cases, the numbers of prior authorization requests are so low for MH/SUD that a handful of reviews not meeting criteria are enough to drastically change the overall percentage of approvals. However, this reflects on the limited number of cases and clinical presentation of the small number of cases instead of a more stringent application of the process overall.

Anthem has also reviewed the turnaround times for requests, and there is no measurable difference demonstrating that prior authorization requirements are being applied more stringently in the timeframe for determinations between MH/SUD and M/S requests. The turnaround time metrics are included in Exhibit 7.



As demonstrated by these Exhibits, Anthem does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits.

Thus, Anthem treats MH/SUD services no less favorably than medical/surgical services when determining whether to include such a service on the prior authorization list.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. Anthem applies the same factors, standards, and processes to determine whether a particular M/S and MH/SUD service should be added or removed from the prior authorization list. The CCRT and the Medical Directors reviewing the services consider the same factors in making the clinical decisions of whether to add or remove a service from the prior authorization list. However, as noted above, consideration of MH/SUD, beyond an annual update, is not frequently considered in this process as relatively few MH/SUD procedures are introduced requiring changes to the prior authorization list. Therefore, the factors, standards, and sources are more often considered for M/S services.

In operation, the prior authorization process is the same for each, with the critical components to the requests and supporting documentation generally being the same although tailored to the specific service subject to the request. M/S and MH/SUD providers have multiple available avenues to submit a request for prior authorization, and the usage of one particular avenue or form is not mandated. Finally, the in operation data demonstrates that Anthem receives significantly more M/S prior authorization requests than MH/SUD, yet the percentage approval of MH/SUD service requests is often higher than M/S. MH/SUD services have a similar turnaround time in the prior authorization determination process. Lastly, based on the list above, a significantly higher number of M/S services require prior authorization. Therefore, Anthem is within the parity requirements for MH/SUD as prior authorization is not applied more stringently to MH/SUD services than M/S services.



## EXHIBIT 1

### Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

#### Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis in a Hospital setting but may be approved at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Certain services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

**Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:**

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

#### Types of Reviews



· **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

**Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us with 48 hours of admission, or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

· **Continued Stay / Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

· **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

### Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor (“requesting Provider”) will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	<ul style="list-style-type: none"><li>• The Provider must get Precertification when required</li></ul>
Out-of-Network / Non-Participating	Member	<ul style="list-style-type: none"><li>• Member must get Precertification when required (Call Member Services).</li><li>• Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is</li></ul>





		found to not be Medically Necessary.
BlueCard Provider	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"><li>• Member must get Precertification when required. (Call Member Services.)</li><li>• Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.</li><li>• BlueCard Providers must obtain precertification for all Inpatient Admissions.</li></ul>
Note: For an Emergency Care admissions, precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

### **How Decisions are Made**

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the “Complaints and Appeals” section to see what rights may be available to you.

### **Decision and Notice Requirements**

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	24 hours from the receipt of request





Non-Urgent Pre-service Review	72 hours, or 2 business days, whichever is less from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	1 business day from the receipt of the request
Non-urgent Concurrent Continued Stay Review for ongoing outpatient treatment	1 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

Anthem Blue Cross and Blue Shield

# Georgia Facility and Professional Provider Manual

Effective October 1, 2022



Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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# Introduction and Guide to Manual

Anthem is committed to working with Providers and Facilities to meet the needs of Members. This Provider Manual (“Manual”) contains important information regarding key administrative requirements, policies and procedures including but not limited to Claims submission, reimbursement and administrative policies and requirements, credentialing, utilization management and quality improvement. This Manual contains many references to additional policies, procedures, forms, and other useful information that will be found and maintained on the website at [www.anthem.com](http://www.anthem.com). The Agreement with Anthem requires Providers and Facilities to comply with Anthem policies and procedures including those contained in this Manual. Payment may be denied, in full or part, based upon the Provider or Facilities failure to comply with the Manual. However, in the event of an inconsistency between the Agreement and this Manual, the Agreement will govern.

This Manual is intended to support all entities and individuals that have executed a Provider or Facility Agreement with Anthem. The use of “Provider” within this manual refers to entities and individuals contracted with Anthem that submit professional Claims. They may also be referred to as Professional Providers in some instances. The use of “Facility” within this manual refers to entities contracted with Anthem who submit institutional Claims, such as Acute General Hospitals and Skilled Nursing Facilities. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.

Capitalized terminology in this Manual is defined in the Anthem Facility Agreement or Anthem Provider Agreement otherwise referred to in this Manual as “Agreement”. The provisions of this Manual apply unless otherwise required by the Agreement.

This Manual may be updated at any time and is subject to change. If there is a material change to this Manual, then Anthem will make reasonable efforts to notify Providers and Facilities in advance of such change through web-posted newsletters or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive. This Manual is not intended to be a complete catalog of all Anthem policies and procedures. Other policies and procedures not included in this Manual may be posted on the Anthem website or published in specially targeted communications, including but not limited to bulletins and newsletters. This Manual does not contain legal, tax or medical advice. Providers and Facilities should consult their advisors for advice on these topics.

## Legal and Administrative Requirements

### **ADMISSION, DISCHARGE AND TRANSFER MESSAGING DATA**

Facilities must provide Anthem with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all Members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer required message data segments according to the standard HL7 format, or as requested by Anthem. For purposes of this section, “near real-time basis” means no later than twenty-four (24) hours from admission, discharge or transfer of any Members.

## AFFILIATES

Affiliates are an important concept in Anthem's Provider and Facility Agreements, as these entities access the rates, terms or conditions of the Agreements.

To view a current listing of Anthem Affiliates visit **Anthem.com**, select **Providers**, select **Forms and Guides** (under the Provider Resources column), if needed Select a State at the top right, then scroll down and select **Contracting & Updates** in the Category drop down and select **Affiliated Companies**.

## COORDINATION OF BENEFITS

If a Member or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most Health Benefit Plans.

If a Plan is other than the primary payor, any further compensation to Provider or Facility from Plan or the Member be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from Plan as a secondary payer plus the amounts owed by all other sources, including the Member, shall add up to one hundred percent (100%) of the Plan rate.

Notwithstanding the foregoing, in no event shall Plan or the Member be required to pay more than they would have paid had the Plan been the primary payor. Providers and Facilities will not collect any amount from the Member if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to the Provider or Facility for the Covered Service to exceed the amount allowed for the Covered Service under the Agreement. Further, this provision shall not be construed to require Providers or Facilities to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Providers and Facilities are permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan's Health Benefit Plan. Providers and Facilities may seek payment from the other sources on a basis other than the Plan rate.

### Make the Most of Electronic Coordination of Benefits (COB) Submissions

Availity is Anthem's designated electronic data interchange (EDI) Gateway. Availity provides a Companion Guide, to assist Providers and Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. To learn more, Providers and Facilities should contact their EDI vendor or go to [www.availity.com](http://www.availity.com). When filing Coordination of Benefits Claims on paper submission

Include Explanation of Benefit. ("EOB") from primary insurance carrier with coordination of benefits ("COB") Claims submitted for secondary payment.

## DISPUTE RESOLUTION AND ARBITRATION

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Provider Agreement (the "Agreement") or the Anthem Facility Agreement (the "Agreement"). All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand. The following provisions set forth the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Fees and Costs

All fees and costs associated with neutrals, logistics, and administration of confidential non-binding mediation and confidential binding arbitration (i.e. mediator travel and fee, arbitrator(s) travel and fee(s), arbitration association administrative costs, etc.) shall be shared equally between the parties. Each party shall be responsible for the payment of its own fees and costs that the party incurs (i.e. attorney fees, experts, depositions, document production, e-discovery, etc.). Notwithstanding this provision, the arbitrator or panel of arbitrators may issue an order in accordance with Federal Rule of Civil Procedure Rule 11 or the respective state rule counterpart awarding a party its fees if that party requested fees under Rule 11, or the respective state court counterpart rules in its initial pleadings.

B. Location of the Arbitration

The arbitration hearing will be held in the city and state in which the Anthem office, identified in the address block on the signature page to the Agreement, is located except that if there is no address block on the signature page, then the arbitration hearing will be held in the city and state in which the Anthem Plan identified in the Agreement has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location. Arbitration hearings should be in person, the in person format shall be given precedent and used, unless good cause and unforeseen circumstances are shown why the hearing should be virtual.

C. Selection and Replacement of Arbitrator(s)

For disputes equal to or greater than (exclusive of interests, costs or fees) the dollar thresholds set forth in the Agreement, the arbitration panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider/Facility, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators, or by the parties through a strike list provided by the arbitration administrator identified in the Agreement. If the arbitrators selected by Provider/Facility and Anthem cannot agree in thirty (30) calendar days on who will serve as the independent arbitrator, then the arbitration administrator identified in the Agreement shall appoint the independent arbitrator. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Consolidation

The arbitrator or panel of arbitrators does not have the authority to consolidate separately filed arbitrations, for discovery or otherwise, without written consent and agreement by the parties. The arbitrator or panel of arbitrators does not have the authority to permit Providers or Facilities under separate Agreements with Anthem to bring one arbitration action without written consent and agreement by the parties. Rather, each Provider or Facility with separate Agreements should file for separate arbitration in its own name, unless there is written consent and agreement by the parties to consolidate the action, in some fashion.

E. Discovery

The parties recognize that litigation in state and federal courts can be costly and burdensome. One of the parties' goals in providing for disputes to be mediated and arbitrated

instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34. The parties shall confer and draft an Order Regarding Procedures for Production Format and Electronic Discovery, which shall be presented to the arbitrator or panel of arbitrators for review, approval and entry.

**F. Decision of Arbitrator(s)**

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding upon the parties. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law. The arbitrator(s) shall not toll or modify any applicable statute of limitations, set forth in the Agreement, or controlling law if the Agreement is silent. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Agreement, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request either a reasoned award or decision, or findings of facts and conclusions of law, and if either party makes such a request, the arbitrator(s) shall issue such an award or decision setting forth the factual and legal basis for the decision.

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56.

Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located, as identified in the address block on the signature page to the Agreement, and of the United States District Courts sitting in the State(s) in which Anthem is located, as identified in the address block on the signature page to the Agreement, for confirmation, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

If a party files an interim award, award or judgment with a state or federal district court, then all documents must be filed under seal to ensure confidentiality as outlined below, and only the portions outlining the specific relief or specific enforcement or performance shall be filed and the remainder of the opinion or decision shall be redacted.

A decision that has been appealed shall not be enforceable while the appeal is pending.

**G. Interest**

Providers or Facilities agree that the state's statutory pre-judgment interest statute is inapplicable to Dispute Resolution and Arbitration. Should the arbitrator(s) determine that pre-judgment interest is appropriate and issue an award including it, pre-judgment shall be simple, not compounded, at an annual percentage rate no more than five percent (5%) or the interest applied for "clean claims", whichever is less. If an award is issued and it includes post-judgment interest, it will not begin accruing until thirty (30) business days after the date of the award to allow time for payment. If an appeal is taken by either side, the obligation to pay any

damages and/or interest awarded shall be tolled until a decision is reached as the result of the appeal.

#### H. Confidentiality

Subject to any disclosures that may be required or requested under state or federal law, all statements made, materials generated or exchanged, and conduct occurring during the arbitration process including, but not limited to, materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained. Nothing in this provision, however, shall preclude Anthem or its parent company from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers, retrocessionaires or affiliates and Other Payors whose Claims have been at issue in the arbitration, including Administrative Services Only (ASO) groups and other Blue Plans.

## **FACILITY BASED PHYSICIANS**

Facility based physicians are physicians, with the exception of residents, interns and fellows, who have a contractual relationship with one or more Facilities to provide professional services. These services may be of either of the following types: (1) administrative, managerial, teaching, or quality management activities compensated by the Facility and that are furnished to the Facility or its general population; or (2) physician services personally rendered to a Member while in the Facility that directly contribute to the diagnosis or treatment of a Member and which ordinarily require performance by a physician, including but not limited to, an emergency room physician, radiologist, pathologist, neonatologist, hospitalist or anesthesiologist. Facility based physicians do not include Primary Care Physicians (“PCP”) or Specialty Care Physicians who are employed by the Facility and have a separate contractual Agreement with Anthem.

Anthem and Facility will make commercially reasonable efforts to require each of the contracted or employed Facility based physicians to maintain an Agreement, as appropriate, with Anthem at the current Anthem market rates. When a new Facility based physician (or group of physicians) joins the Facility, the Facility shall be provided sixty (60) days to cause such Facility based physicians to execute Agreement(s) with Anthem. Until such time as Facility-based physicians enter into Agreements with Anthem, Facility agrees to fully cooperate with Anthem to prevent Members from being billed amounts in excess of the applicable Anthem non-participating reimbursement for such Covered Services. Facility-based physicians may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

In addition, the Facility shall take any action necessary to ensure that its contracted Facility based physicians cooperate with, participate in and are bound by the Anthem utilization and quality management programs and coordinate as appropriate with the admitting physician and PCP.

## **FINANCIAL INSTITUTION/MERCHANT FEES**

Providers and Facilities are responsible for any fees or expenses charged to it by their own financial institution or payment service Provider.

## HOME DELIVERY PHARMACY PRESCRIPTION DRUG PROGRAM

Members covered under a Prescription Drug Program may have maintenance prescriptions filled through the Home Delivery pharmacy for benefit information, refer to the back of the Member's id card.

Maintenance drugs are defined as: approved by the FDA for long-term use for chronic conditions; considered reasonably safe when dispensed in large quantities of up to a 90-day supply; and must not have a potential for abuse.

Maintenance prescriptions may be written for up to a ninety (90) day supply with refills.

For NEW maintenance medications it is recommended that the PCP write two prescriptions:

- one for up to a ninety (90) day\* supply plus refills, to be mailed to Anthem's designated Pharmacy Benefit Manager and
- a second one, for a thirty (30) day supply, to be filled immediately at a retail pharmacy.

\*Note: By law, Home Delivery Pharmacy must fill the prescription for the exact quantity of medication prescribed (e.g., "30 days plus two refills" does not equal one prescription written for "90 days.")

BlueChoice Providers and Members may call Anthem Customer Service regarding this program.

## INSURANCE REQUIREMENTS

Providers and facilities shall self-insure or maintain insurance in types and amounts reasonably determined by Providers and facilities, or as required under applicable licensing or regulatory requirements.

## MISROUTED PROTECTED HEALTH INFORMATION (PHI)

Providers and Facilities are required to review all Member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact the local Provider Services to report receipt of misrouted PHI.

## LABORATORY TESTS

Laboratory testing must be sent to a Anthem in-network laboratory Provider. Any lab work referred to an out-of-network laboratory without approval prior to services being rendered, will be the financial responsibility of the referring physician

To the extent the physician draws any lab work or performs any laboratory diagnostic testing in his/her office for any patient, the physician shall perform such in-office testing for Anthem Members. Patient service centers are to be used only by Providers who do not draw any lab work in their office.

Laboratory Corporation of America ("LabCorp") is the reference laboratory Provider for Pathway, HMO/POS, Open Access Members. All laboratory testing for Pathway, HMO/POS, Open Access Members must be referred to LabCorp except those that have been approved as in-office



laboratory tests. Approved in-office laboratory procedure codes will be reviewed periodically for additions, deleted and replacement codes.

LabCorp requisition forms must be completed and accompany the Member to the patient service center. Ensure the requisition is completed correctly. Go to [www.labcorp.com](http://www.labcorp.com) for LabCorp's laboratory requisition procedures and to search for LabCorp Patient Service Centers.

## NON-COMPLIANCE POLICY

The purpose of the Non-Compliance Policy is to monitor and assure compliance with Anthem administrative and UM policies and operational requirements pursuant to Agreements with Providers.

Anthem will notify Provider of any documented occurrence of administrative non-compliance with their Agreement. Anthem will track occurrences and provide notification and necessary education to the Provider and staff.

Examples of administrative non-compliance include, but are not limited to:

- Balance billing Members when Member has no financial liability,
- Failure to use/call in a network physician to admit an Anthem Member from the emergency room,
- Referral of a Member to an out-of-network Provider,
- Failure to obtain required pre-authorization for admissions and/or procedures,
- Failure to provide timely information for prospective reviews,
- Failure to call in a Network physician for a specialist consultation,

Contact a [Provider Experience Representative](#) with questions regarding the non-compliance policy <https://www.anthem.com/provider/contact-us/email-form/>.

## NATIONAL PROVIDER IDENTIFIER (“NPI”)

The National Provider Identifier (“NPI”) is a component of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The NPI is a ten (10) digit single Provider identification number the Centers for Medicaid and Medicare Services (“CMS”) assigns through the National Plan and Provider Enumerator System (“NPES”) to uniquely identify a physician, other health care professional or institution within specified electronic HIPAA transactions. It is intended to improve the efficiency of the health care system and reduce fraud and abuse.

The NPI has replaced all existing identification numbers including the Medicare, Medicaid, Unique Physician Identification Number (“UPIN”) and plan Provider identification numbers.

Note if NPI numbers submitted are INVALID, Anthem will be unable to complete the processing of Claim(s). Correct tax identification number (“TIN”) and billing address must be included when filing a Claim.

## OPEN PRACTICE

Provider shall give Anthem sixty (60) days prior written notice when Provider no longer accepts new patients.

## PREFERRED DRUG LIST

The objective of the Preferred Drug List (often referred to as “Preferred Drug Formulary”) is to ensure quality and cost-effective prescription drug coverage at an affordable price for Members. The Pharmacy and Therapeutics (“P&T”) Committee, composed of practicing physicians and pharmacists, has selected safe and effective products for coverage under the Preferred Drug List. The Preferred Drug List is supported by sound medical guidelines and treatment protocols researched from current pharmacological literature, reference books and peer-reviewed journals.

The Preferred Drug List includes coverage for many single-source brand name drugs, essentially all generic equivalent products, and some multi-source brand agents. The Preferred Drug List also targets Anthems most highly-utilized therapeutic categories. Within these top classes, single-source brand name drugs are limited to a specific list. Those drugs not included on the Preferred Drug List are considered non-preferred or non-formulary. Non-preferred agents are not considered a covered prescription benefit unless they meet criteria established by the P&T Committee and approved by the Plan. The Anthem Prescription Drug Program includes an exception process to provide coverage for a non-preferred drug prescribed by a Provider when, in Providers professional judgment, no effective alternative is available on the Preferred Drug List. This process documents the need for an exception when a formulary/preferred product has been proven to be ineffective or causes adverse or harmful reactions to the patient. Visit [www.Anthem.com](http://www.Anthem.com) for more details.

Providers, are asked to prescribe products from the Preferred Drug List for all Anthem Members. By prescribing preferred drugs when appropriate, Providers help contain the rising costs of health care, ensure the use of high quality pharmaceuticals, and help maintain patients’ continued drug coverage. Anthem asks that Providers assure patients of the safety and efficacy of generic equivalents. Use the Preferred Drug List when prescribing to Anthem Members. To receive a copy of the most current Preferred Drug List, go to [www.Anthem.com](http://www.Anthem.com) or contact a local Provider Experience Manager.

Specific drugs may require preauthorization. Specific preauthorization request form will apply to these drugs. The drug-specific preauthorization forms are available on [www.Anthem.com](http://www.Anthem.com).

## PROVIDER AND FACILITY DIGITAL ENGAGEMENT

Anthem expects Providers and Facilities will utilize digital tools unless otherwise mandated by law or other legal requirements for transactions such as filing Claims, verifying eligibility and benefits, etc. Providers and Facilities should refer to the guidance included throughout the Provider Manual where digital tools are available. For a complete list of digital tools, refer to the Provider Digital Engagement Supplement located on [anthem.com](http://anthem.com). To access the Provider Digital Engagement Supplement, go to [anthem.com](http://anthem.com), select **Providers**, select **Forms and Guide** (under the Provider Resources column), if needed Select or Change a State at the top right, select Category **Digital Tools** and scroll to the [Provider Digital Engagement Supplement](#)

## PROVIDER AND FACILITY RESPONSIBILITIES

Providers and Facilities are responsible for notifying Anthem when changes occur within the Provider practice or Facility. Providers and Facilities should reference their Agreement for specific timeframes associated with change notifications.

Examples of these changes include, but are not limited to:

- adding new or removing practitioners to the group
- change in ownership



- change in Tax Identification Number
- making changes to demographic information or adding new locations
- selling or transferring control to any third party
- acquiring other medical practice or entity
- change in accreditation
- change in affiliation
- change in licensure or eligibility status, or
- change in operations, business or corporation
- Any change in its ownership or business address;
- Any legal or governmental action or any other problem or situation which might impair the ability of Facility to carry out its duties and obligations under its Anthem Agreement(s) including, but not limited to, employee strikes or walkouts, financial insolvency, or damage to the physical plant resulting in any interruption in medical services;
- Any written complaint, Claim or suit or threat of legal action by a Member against the Facility or the Facility's medical staff;
- Any action taken by Facility or its medical staff against a physician;
- Any change or notification of possible change in professional licensure of staff Member or a physician; and

A Facility must provide at least one hundred twenty (120) days prior written notice of the intention to add, limit or delete any Facility or service. This would include the addition of any freestanding Facilities.

## **REFERRING TO NON-PARTICIPATING PROVIDERS**

Anthem's mission is to provide affordable quality health care benefits to its Members. Members access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out-of-pocket expenses when they refer to non-participating Providers in non-emergent situations or without Anthem's prior approval. Anthem has established Maximum Allowed Amounts for services rendered by non-participating Providers. Once Anthem determines the appropriate Maximum Allowed Amount for services provided by a non-participating Provider, the payment will be remitted to the Member in most situations rather than the non-participating Provider; and Members may be balance-billed by non-participating Providers for the difference between the amount they charge for the service and the amount paid to that non-participating Provider.

Providers and Facilities are reminded that pursuant to their Agreement with Anthem they are generally required to refer Members to other Network/Participating Providers and Facilities. Providers and Facilities who establish a pattern of referring Members to non-participating Providers may be subject to disciplinary action, up to and including termination from the Network. Anthem understands that there may be instances in which Providers and Facilities must refer to a non-participating Provider. For additional information on in-network and out-of-network referrals, Providers and Facilities should refer to the applicable sections of their Agreement with Anthem.

## RISK ADJUSTMENTS

### Compliance with Federal Laws, Audits and Record Retention Requirements

Medical records and other health and enrollment information of Members must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Member information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Member, Anthem, Providers and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

### Encounter Data for Risk Adjustment Purposes

- Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services (“HHS”) to adjust the payment made to health plans under the Affordable Care Act (“ACA”) based on the health status of Members who are insured under small group or individual health benefit plans compliant with the ACA (aka “ACA Compliant Plans”). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Members by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as a qualifying health plan, is required to submit diagnosis data collected from encounter and Claim data to HHS for purposes of risk adjustment. Because HHS requires that health plans submit all ICD10 codes for each beneficiary, Anthem also collects diagnosis data from the Members’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician e.g. nurse practitioner encounters only.

Maintaining documentation of Members’ visits and of Members’ diagnoses and chronic conditions helps Anthem fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or “3Rs” provision in the ACA. To ensure that Anthem is reporting current and accurate Member diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Members insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. Anthem’s goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider’s Agreement with Anthem, the Provider or Facility shall comply with Anthem’s requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to Anthem, Plan or designee upon request. Providers and Facilities also agree to cooperate with Anthem’s, or its designee’s, requests to reach out to patients to request appointments or encounters so additional information can be collected to resolve any gaps in care (example - blood tests in certain instances) and to provide the updated and complete Member health information to Anthem to help it fulfill its requirements under the Affordable Care Act.

In addition to the above ACA related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Members enrolled in Medicare Advantage or Medicaid.

## **RADV Audits**

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the Members' diagnosis data that was previously submitted by health plans. These audits are typically performed once a year. If the health plan is selected by HHS to participate in a RADV audit, the health plan and the Providers or Facilities that treated the Members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

## **ICD-10 CM Codes**

HHS requires that physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding practices services under ACA Compliant Plans. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity which includes fully documenting the patient's diagnosis.

## **Medical Record Documentation Requirements**

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the health plans.

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

HHS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record.
- Patient's condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT), or there is evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral (TAMPER).
- The documentation describing the condition and MEAT or TAMPER must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician's/Qualified Non-Physician's signature, credentials and date must appear on record and must be legible.

# Capitated Services

## Capitated Specialty Network Administration

### BlueChoice HMO and BlueChoice Option only

Network	Area	Network Name	Network Administrator
Allergy	Atlanta Area Only	Atlanta Allergy & Asthma Clinic 1965 North Park Place, NW Suite 540 Atlanta, GA 30303 (770) 952-8612 David Tanner, MD – Medical Director	Anthem Claims: PO Box 105187 Atlanta, GA 30348 Correspondence: Anthem
Lab	Statewide	LabCorp	N/A
Neurosurgery	Atlanta Area Only	Georgia Neurosurgical Affiliates 1117 Perimeter Center West Suite W213 Atlanta, GA 30338 Administrator: Howard Fagin Medical Directors: Michael Goodman, MD H. Dale Richardson, MD	Anthem Claims: PO Box 105187 Atlanta, GA 30348  Correspondence: Anthem

\*Atlanta Area Only

# Anthem Digital Tools

## ANTHEM PROVIDER WEB SITE

Anthem.com is a public website. [www.anthem.com](http://www.anthem.com)

Anthem designed the Provider public website to make navigation easy and more useful for Providers and Facilities. The website holds timely and important information to assist Providers when working with Anthem. Go to **anthem.com** and **Select Providers** from the horizontal menu. On the **Providers Overview page**, pick Georgia > and choose content available.

Providers and Facilities can also sign-up for the Network eUpdates to be notified when a newsletter is published. Newsletters are designed to educate Providers, Facilities and their staff on updates and notification of changes. To sign up go to **anthem.com**, Select **Providers**, **Providers Overview** and **Georgia**. Scroll down and select **Read the Most Recent Provider News**. On the Provider Communications page select **Subscribe to Email**.

Some items that can be located from the Provider Home page or the horizontal menu include:

- Provider Resources
  - Forms and Guides
  - Policies, Guidelines & Manuals
  - Provider Maintenance
  - Pharmacy
  - Behavioral Health Provider Resources
  - Dental
  - Find Care
  - Availability
- Claims
  - Claim Submission
  - Electronic Data Interchange (EDI)
  - Prior Authorization
- Patient Care
  - Medicare Advantage
- Communications
  - News
  - Contact Us
- Join Our Network
  - Getting Started with Anthem
  - Credentialing
  - Employee Assistance Program (EAP)

## ONLINE PROVIDER DIRECTORY & DEMOGRAPHIC DATA INTEGRITY

Providers and Facilities are able to confirm their Network participation status by using the Find a Doctor/Find Care tool. A search can be done on a specific Provider name or by viewing a list of local in-network Providers and Facilities using search features such as Provider specialty, zip code, and plan type.

### Online Provider Directory

Accessing the Online Provider Directory:

- Go to [anthem.com](https://www.anthem.com)
- Select the **Find a Doctor/Find Care** link at the top right of the page. **Select a state.**
- To search the online Provider Directory either enter the Member information or enter as guest.

*Before directing a Member to another Provider or Facility, verify that the Provider or Facility is participating in the Member's specific network.*

To help ensure Members are directed to Providers and Facilities within their specific Network, utilize the Online Provider Directory one of the following ways:

- **Search as a Member:** Search by entering the Member's ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
- **Search as a Guest:** Search by Selecting a Plan and Network. Note: The Member's Network Name should be on the lower right corner of the front of the Member's ID card.

Providers and Facilities who have questions on their participation status listed in the online directory should contact the number on the back of the Member's ID card.

### Updating Demographic Data with Anthem

It is critical that Members receive accurate and current data related to Provider availability. Providers and Facilities must notify Anthem of any demographic changes. All requests must be received 30 days prior to change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date request.

***IMPORTANT:** If updates are not submitted 30 days prior to the change, Claims submitted for Members may be the responsibility of the Provider or Facility.*

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)
- Areas of Expertise (Behavioral Health Only)
- Email Address
- Handicapped Accessibility
- Hospital Affiliation and Admitting Privileges
- Languages Spoken
- License Number
- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice\*
- Specialty
- Tax Identification Number (TIN) (must be accompanied by a W-9 to be valid)
- Termination of Provider Participation Agreement\*\*
- Web Address

Send Anthem this information using the **Provider Maintenance Form**

- <https://www.anthem.com/provider/provider-maintenance-form/>

\* To request participation for a new Provider or practitioner, even if joining an existing practice, Providers or practitioners must first begin the Application process. Go to **anthem.com**. Select **Provider**, and under the **Join our Network** heading select the **Getting Started with Anthem** link. Next, select **Begin Application**, and **Select a State**, if necessary.

**\*\*For notices of termination from an Anthem network, Providers and Facilities should refer to the termination clause in the Agreement for specific notification requirements. Allow the number of days' notice of termination from Anthem's network as required by the Agreement (e.g. 90 days, 120 days, etc.).**

## AVAILITY PORTAL

Anthem is offering an array of valuable online tools through the Availity Portal, a secure multi-health plan portal. Refer to the Provider Digital Engagement Supplement to learn more about Anthem's efforts to go digital. To access the [Provider Digital Engagement Supplement](#), go to **anthem.com**, select **Providers**, select **Forms and Guide** (under the Provider Resources column), if needed **Select or Change a State** at the top right, select Category **Digital Tools** and scroll to the **Provider Digital Engagement Supplement**.

### Engage and obtain the information needed instantly with the following tools:

- **AIM Specialty Health:** Access link to precertification requests and inquiries for specific services and access the OptiNet® Survey when applicable.
- **Claim Submission:** Submit a single, electronic Claim.
- **Claim Status Inquiry:** See details and payment information including Claim line-level details/processing.
- **Interactive Care Reviewer:** Secure, online Provider authorization, referral and inquiry tool for many Anthem Members. Determine if an authorization is required, submit an authorization request, view the status of a submitted authorization, submit a UM appeal and view the status of a UM appeal.
- **Medical Attachments:** Submit both requested and unsolicited medical records electronically to support a pending or denied Claim. Includes the ability to submit an itemized bill electronically.
- **Member Certificate Booklet:** View a local plan Member's certificate of coverage, when available
- **Member Eligibility and Benefits Inquiry:** Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL Members, including BlueCard® and FEP®.
- **Member ID Card Viewer:** View the front and back of a Member's ID card when available.
- **Secure Messaging:** Send a question to clarify the status of a Claim or to get additional information on Claims, where applicable.

### Payer Spaces:

View Anthem specific tools by selecting **Payer Spaces**, then the correct payer tile to view the following Anthem specific applications:

Now Featuring: **Chat with Payer** - Using **Chat with Payer** to have Provider services questions answered is a digital alternative to calling.

- **Authorization Look Up Tool:** Determine if an authorization is needed for a commercial Member for a specific outpatient medical or behavioral health service.



- **Chat with Payer:** Providers and Facilities can chat with an online representative about prior authorizations, appeals, Claims, eligibility and more.
- **Clear Claim Connection:** Research procedure code edits and receive edit rationale.
- **Custom Learning Center:** Access payer-centric training and educational videos.
- **Information Center:** Locate important policies and forms.
- **Remittance Inquiry:** View an imaged copy of the paper Anthem remits up to 15 months in the past.
- **Patient360:** A robust picture of a Member's health and treatment history, including gaps in care and care reminders.
- **Provider Online Reporting:** Access proprietary Provider specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Provider Enrollment:** Submit an online request to join Anthem's Provider network.
- **Provider Maintenance Form (under Resources):** Request changes to existing practice profiles.
- **Plus,** links to other Anthem pages, tool overview documents and more.

#### Take advantage of these Availity benefits

- **No charge:** Anthem transactions are available at no charge to Providers.
- **Accessibility:** Availity functions are available 24 hours a day from any computer with Internet access.
- **Standard responses:** Responses from multiple payers returned in the same format and screen layout, providing users with a consistent look and feel.
- **Access to both commercial and government payers:** Users can access data from Anthem, Medicare, Medicaid and other commercial insurers (See [www.availity.com](http://www.availity.com) for a full list of payers.)
- **Compliance:** Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

#### Getting Started and Availity Training

To register for access to Availity, go to [www.availity.com/providers/registration-details/](http://www.availity.com/providers/registration-details/). For additional assistance in getting registered, contact Availity Client Services at 1-800-AVAILITY (282-4548).

After logging into Availity, Providers and Facilities have access to many resources to help jumpstart learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources to help ensure Providers and Facilities get the most out of the Availity experience. Availity also offers onboarding modules for new Administrators and Users.

For more information on navigating in Availity, select **Help & Training** (from the top navigation menu on the Availity home page) | **Get Trained**, and type "*onboarding*" in the search catalog field.



## Availity Training for Anthem specific tools

For more information on Anthem features and navigation, select **Payer Spaces | Applications | Custom Learning Center** to access presentations and reference guides that can be used to educate Provider staff on Anthem proprietary (exclusive) tools.

## Organization Maintenance

To change/update an Administrator or Organization information:

- To replace the Administrator currently on record with Availity, call Availity Client Services at 1-800-AVAILITY (282-4548).
- An Administrator can use the Maintain Organization feature to maintain the organization's demographic information, including address, phone number, tax ID, and NPI. Any changes made to this information automatically apply to all Users associated to the organization and affects only the registration information on the Availity Portal.

## Support

If Providers and Facilities need help, or run into technical difficulties, submit a support ticket through Availity:

1. Log in to Availity at [www.availity.com](http://www.availity.com)
2. Select **Help & Training > Availity Support**
3. Select organization > **Continue**
4. Select **Contact Support** from the top menu bar then **Create Case**

# Credentialing

Credentialing is the process Anthem uses to evaluate and select healthcare practitioners and health delivery organizations (HDOs) to provide care to Members to help ensure that Anthem's standards of professional conduct and competence are met. Anthem's Program Summary includes a complete list of the Provider types within Anthem's credentialing scope. The credentials of health care practitioners and HDOs are evaluated according to Anthem's criteria, standards, and requirements as set forth in the Program Summary and applicable state and federal laws, regulatory, and accreditation requirements and are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of Anthem's Credentialing Program nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend, or terminate individual practitioners and HDOs in those instances where it has delegated credentialing decision-making. Anthem's Credentialing Program also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards. All applicable practitioners and HDOs in Anthem's network within the scope of the Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by applicable state contract or state regulations. Additional information regarding Anthem's Credentialing Program can be found in the Program Summary, which applicable terms are incorporated into this Provider Manual by reference," available on

Anthem.com. Go to **Anthem.com**, Select **Provider** and then **Credentialing** under **Join Our Network**, **Select** or **Change State** if needed, then select the **Program Summary** under the question, **Who do we Credential?**

## Standards of Participation

Anthem contracts with many types of Providers that do not require credentialing as described in the **Credentialing Program Summary** available on Anthem.com. However, to become a Network/Participating Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this manual, and standards of participation and accreditation requirements outlined in the Provider Agreement, the chart below outlines requirements that must be met in order to be considered for contracting as a Network/Participating Provider or Facility in one of these specialties:

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification/State Licensure
Ambulatory Event Monitoring	Medicare Certification
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA, TJC
Durable Medical Equipment	TJC (JCAHO), CHAP, ACHC, (HQAA) Medicare Certification, The Compliance Team
Hearing Aid Supplier	State Licensure
Intermediate Care Facilities	Medicare Certification/State Licensure
Immunization Clinic	CDC Certification Pharmacy License, Medicare Certification
Orthotics & Prosthetics	TJC, CHAP, The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or Board of Certification/Accreditation (BOC) Ocularist: National Examining Board of Ocularists NEBO Preferred) Medicare Certification
Private Duty Nursing	TJC, CHAP, CTEAM, ACHC, or DNV/NIAHO
Urgent Care Center (UCC)	AAAHHC, IMQ, NUCCA (formerly ABUCM), TJC, UCAOA

\* **Note:** This is only a representative listing of Provider types that do not require formal credentialing. For questions about whether a Provider or Facility is subject to the formal credentialing process or the applicable standards of contact Network Management.

## Claims Submission

### ELECTRONIC CLAIMS SUBMISSIONS

Providers and Facilities are expected to submit Claims electronically whenever possible. Claims must be submitted within the timely filing timeframe specified in the Provider or Facility Agreement. Refer to the EDI Submissions section in this Manual for more details about electronic submissions, and to learn more about how EDI can work for Providers and Facilities.

#### Recommended Fields for Electronic 837 Professional (837P) and Institutional (837I) Health Care Claims

Reference the Transaction Specific Companion Documents available on the EDI webpage. Go to [www.anthem.com/edi](http://www.anthem.com/edi). **Select a state** from the dropdown list and **enter**. Under the *Documents tab*, select **Companion Guide** then see the appropriate link under the *Section B – Transaction Specific Companion Documents* heading.

### CLAIM SUBMISSION FILING TIPS

Eliminate processing delays and unnecessary correspondence with these Claim filing tips:

#### Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the Claim helps us process the Claim correctly and more quickly. Ambulatory surgical Claims must be billed on a CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04), as indicated in the Agreement.

#### Ancillary Filing Guidelines

##### Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- File the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- The POP (Point of Pick-up) ZIP Code should be submitted as follows:
  - *Professional Claims* – for CMS-1500 submitters: the POP ZIP code is reported in field 23
  - *Institutional outpatient Claims* – for UB submitters: the Value Code of 'A0' (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

##### Durable/Home Medical Equipment and Supplies

- Durable/Home Medical Equipment and Supplies (D/HME) is determined by the Provider specialty code in the Provider file, not by CPT codes.

- **Delivered to patient's home** – File the Claim to the plan in the service area where the item was sent/delivered.
- **Purchased at retail store** – File the Claim to the plan in the service area where the retail store is located.

#### Home Infusion Therapy - Services and Supplies

- File the Claim with the plan in the service area where the services are rendered or the supply was delivered. Examples: If services are rendered in a Member's home, Claims should be sent to the plan in the Member's state. If Supplies are delivered to the Member's home, Claims should be sent to the plan in the Member's state.

#### Independent Clinical Laboratory Claims

- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring Provider's location (based on NPI)
- Independent lab Claims are determined by place of service 81. Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Anthem requires the CLIA identification number to be submitted based on the applicable method below:
  - ASC X12 837 professional Claim format REF segment as REF02, with qualifier of "X4" in REF01 or
  - Field 23 of the paper CMS-1500

#### Specialty Pharmacy Claims

- File the Claim to the plan in the service area where the referring Provider is located (based on NPI).
- Specialty pharmacy Claims are determined by the Provider specialty code in the Provider file, not by CPT codes.

#### **CPT Coding**

The most current version of the CPT® Professional Edition manual is considered by Anthem as the industry standard for accurate CPT and modifier coding.

#### **Duplicate Claims (aka Tracers)**

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Availity.

#### **Late Charges**

Late charges for Claims previously filed can be submitted electronically. Providers and Facilities must reference the original Claim number when submitting a corrected electronic Claim. If attachments are required, submit them using the *Attachment Face Sheet*. (See Electronic Data Interchange website for instructions as [www.anthem.com/edi](http://www.anthem.com/edi)).

Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a 5 in the 3rd position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. Providers and Facilities should also advise the original Claim# to which the late charges should be added.

## Maternity Delivery Claims

Delivery procedure codes reported on a professional Claim (procedure codes: 59612, 59620, 59400, 59410, 59515, 59614, 59622, 59510, 59610, or 59618) are required to submit with the appropriate Z3A diagnosis code indicating the babies gestational age.

## National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

## Negative Charges

When filing Claims for procedures with negative charges don't include these lines on the Claim. Negative charges often result in an out-of-balance Claim that must be returned to the Provider for additional clarification.

## Not Otherwise Classified ("NOC") Codes

- When submitting Not Otherwise Classified (NOC) codes follow these guidelines to avoid possible Claim processing delays. **Anthem must have a clear description of the item/service billed with a NOC code for review.**
  - If the NOC is for a drug, include the drug's name, dosage, NDC number and number of units.
  - If the NOC is not a drug, include a specific description of the procedure, service or item.
  - If the item is durable medical equipment, include the manufacture's description, model number and purchase price if rental equipment.
  - If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
  - If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

*NOTE: NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be included in the shaded area for item 24 on professional Claim forms, or locator 43 on Facility Claim forms.*

## Occurrence Dates

When billing Facility Claims make sure the surgery date is within the service from and to dates on the Claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the Provider.

## Other Insurance Coverage

When filing Claims with other insurance coverage ensure the following fields are completed and that a legible copy of the Explanation of Benefits (EOB) from the other insurance coverage is attached to the Claim:

### CMS-1500 Fields:

Field 9: Other insured's name

Field 9a: Other insured's policy or group number

Field 9b: Other insured's date of birth

Field 9c: Employer's name or school name (not required in EDI)

Field 9d: Insurance plan name or program name (not required in EDI)

#### UB-04 CMS-1450 Fields:

Field 50a-c: Payer Name

Field 54a-c: Prior payments (if applicable)

#### Including Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB):

When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare's Assignment. When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB04).

#### **Preventive Colonoscopy – correct coding**

Anthem allows for preventive colonoscopy in accordance with state mandates. Colonoscopies which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality are discovered, should be covered under benefits for Preventive Services. This has been an area of much confusion in billing by Providers and Facilities of services. Frequently the Provider and Facility will bill for the CPT code with an ICD-10 diagnosis code corresponding to the pathology found rather than the "Special screening for malignant neoplasms, of the colon."

CMS has issued guidance on correct coding for this situation and states that the *ICD-10 diagnosis code Z12.11 (Encounter for screening for malignant neoplasm of colon) should be entered as the primary diagnosis* and that the ICD-10 diagnosis code for any discovered pathology should be entered as the secondary diagnosis on all subsequent Claim lines.

Anthem endorses this solution for this coding issue as the appropriate method of coding to ensure that the Provider or Facility receives the correct reimbursement for services rendered and that Members receive the correct benefit coverage for this important service.

#### **Type of Billing Codes**

When billing Facility Claims ensure the type of bill coincides with the revenue code(s) billed on the Claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

### **CLAIM INQUIRY/ADJUSTMENT FILING TIPS**

The different types of Claim inquiries should be handled in separate ways depending on what is being requested. Here are some examples:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can utilize Chat with Payer or send a Secure Message through the Availity Portal. If Providers or Facilities are unable to utilize the Availity Portal for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference the *Availity Portal* section in this Manual.

- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (“EOP”). The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.
- **Clinical / Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals refer to the *Clinical Appeals* section within the Provider Manual.
- **Claim Payment Disputes:** Refer to the *Claim Payment Dispute* section for further details.
- **Precertification Disputes:** Precertification disputes should be handled via the process detailed in the letter received from the precertification department. If Providers or Facilities disagree with a clinical decision follow the directions detailed on the letter. Sending precertification/predetermination requests or appeals to the Provider correspondence address may delay responses.
- **Corrected Claims:** Submitting corrected Claims should only be utilized to update information on the Claim form. If the inquiry is about the way the Claim processed refer to the prior sections. If Providers or Facilities have corrections to be made to the Claim submit them according to the Corrected Claim Guidance below.

### Proof of Timely Filing

Claims must be submitted within the timely filing timeframe specified in the Provider or Facility Agreement. All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request. ***Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.***

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the Member, Provider or Facility originally submitted the Claim within the applicable timely filing period. The documentation submitted **must** indicate the Claim was originally submitted before the timely filing period expired.

### ***Acceptable documentation includes the following:***

1. A copy of the Claim with a **computer-printed filing date** (a handwritten date isn’t acceptable)
2. An original fax confirmation specifying the Claim in question and including the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service
3. The Provider or Facility’s billing system printout showing the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service



If the Provider or Facility doesn't have an electronic billing system, approved documentation is a copy of the Member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the Claim was originally filed electronically, a copy of Anthem's electronic Level 2 or the respective clearinghouse's acceptance/rejection Claims report is required; a copy can be obtained from the Provider or Facility's EDI vendor, EDI representative or clearinghouse representative. The Provider or Facility also must demonstrate that the Claim and the Member's name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the Claim must show as accepted to qualify for proof of timely filing. Any rejected Claims must be corrected and resubmitted within the timely filing period.
5. A copy of the Anthem letter requesting additional Claim information showing the date information was requested.

Appeals for Claims denied for failing to meet timely filing requirements must be submitted to Anthem **in writing**. Anthem doesn't accept appeals over the phone.

### Corrected Claim Guidance

When submitting a correction to a previously submitted Claim, submit the entire Claim as a replacement Claim if Providers or Facilities have omitted charges or changed Claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or additional information. To correct a Claim that was billed to Anthem in error, submit the entire Claim as a void/cancel of prior Claim. If there is a zero Member, Provider or Facility liability, then a new Claim is needed vs a corrected Claim.

Type	Professional Claim	Institutional Claim
EDI	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In element CLM05-3 "Claim Frequency Type Code"</li> <li>Use Claim Frequency Type 7</li> </ul>	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In element CLM05-3 "Claim Frequency Type Code"</li> <li>Use Claim Frequency Type 7</li> </ul>
	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In Segment "REF – Payer Claim Control Number"</li> <li>Use F8 in REF)! and list the original payer Claim number is REF02</li> </ul>	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In Segment "REF – Payer Claim Control Number"</li> <li>Use F8 in REF)! and list the original payer Claim number is REF02</li> </ul>
	<b>To indicate the Claim was billed in error (Void/Cancel):</b> <ul style="list-style-type: none"> <li>In element CLM05-3 "Claim Frequency Type Code"</li> <li>Use Claim Frequency Type 8</li> </ul>	<b>To indicate the Claim was billed in error (Void/Cancel):</b> <ul style="list-style-type: none"> <li>In element CLM05-3 "Claim Frequency Type Code"</li> <li>Use Claim Frequency Type 8</li> </ul>
	<b>To confirm the Claim which is being void/cancelled:</b>	<b>To confirm the Claim which is being void/cancelled:</b>



Type	Professional Claim	Institutional Claim
	<ul style="list-style-type: none"> <li>In Segment "REF – Payer Claim Control Number"</li> <li>Use F8 in REF) and list the original payer Claim number is REF02</li> </ul>	<ul style="list-style-type: none"> <li>In Segment "REF – Payer Claim Control Number"</li> <li>Use F8 in REF) and list the original payer Claim number is REF02</li> </ul>
Paper	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In Item Number 22: "Resubmission and/or Original Reference Number"</li> <li>Use Claim Frequency Type 7 under "Resubmission Code"</li> </ul>	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In Form Locator 04: "Type of Bill"</li> <li>Use Claim Frequency Type 7</li> </ul>
	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim.</li> </ul>	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.</li> </ul>
	<b>To indicate the Claim is a void/cancel of a prior Claim:</b> <ul style="list-style-type: none"> <li>In Item Number 22: "Resubmission and/or Original Reference Number"</li> <li>Use Claim Frequency Type 8 under "Resubmission Code"</li> </ul>	<b>To indicate the Claim is a void/cancel of a prior Claim:</b> <ul style="list-style-type: none"> <li>In Form Locator 04: "Type of Bill"</li> <li>Use Claim Frequency Type 8</li> </ul>
	<b>To confirm the Claim which is being void/cancelled:</b> <ul style="list-style-type: none"> <li>In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim.</li> </ul>	<b>To confirm the Claim which is being void/cancelled:</b> <ul style="list-style-type: none"> <li>In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.</li> </ul>

For additional information on Provider complaints and appeals refer to the *Claim Payment Dispute* and *Clinical Appeals* sections.

## NATIONAL DRUG CODES (NDC)

All practitioners and Providers are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions. *Note: These billing requirements will apply to Local Plan and BlueCard Member Claims only, and will exclude Federal Employee Program (FEP) and Coordination of Benefits/ Secondary Claims.*

Line items on a Claim regarding drugs administered in a physician office or outpatient Facility setting for all drug categories will deny if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units

- The valid 11-digit NDC, including the N4 qualifier
- Unit of measure qualifier (F2, GR, ML, UN, ME)
- NDC Units dispensed (must be greater than 0)

### Unit of Measurement Requirements

The unit of measurement codes are also required to be submitted. The codes to be used for all Claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit
- ME - Milligram

### Location of the NDC

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 Claim form or in 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item.



NDC Number Section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package size

### Correcting Omission of a Leading Zero

Providers and Facilities may encounter NDCs with fewer than 11-digits. In order to submit a Claim, Providers and Facilities will need to convert the NDC to an 11-digit number. Sometimes the NDC is printed on a drug item and a leading zero has been omitted in one of the segments. Instead of the digits and hyphens being in a 5-4-2 format, the NDC might be printed in a 4-4-1 format (example, 1234-1234-1), a 5-3-2 format (example, 12345-123-12), or a 5-4-1 format (example, 12345-1234-1).

- If this occurs, when entering the NDC on the Claim form, it will be required to add a leading zero to the beginning of the segment(s) that is missing the zero.
- Do not enter any of the hyphens on Claim forms.

See the examples that follow:

If the NDC appears as...	Then the NDC...	And it is reported as ...
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	01234123401
NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345012312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	12345123401

### Process for Multiple NDC numbers for Single HCPC Codes

- If there is more than one NDC within the HCPCs code, Providers and Facilities must submit each applicable NDC as a separate Claim line. Each drug code submitted must have a corresponding NDC on each Claim line.
- If the drug administered is comprised of more than one ingredient (i.e. compound or same drug with different strength, etc.), Providers and Facilities must represent each NDC on a Claim line using the same drug code.
- Standard HCPCs billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:
  - KO – Single drug unit dose formulation
  - KP – First drug of a multiple drug unit dose formulation
  - KQ – Second or subsequent drug of a multiple drug unit dose formulation
  - JW – Drug amount discarded /not administered to the patient

### How/Where to Place the NDC on a Claim Form

#### 837 Reporting Fields

Providers and Facilities will need to notify billing or software vendors that the NDC is to be reported in the following fields in the 837 format.

Loop	Segment	Element Name	Information	Sample
2410	<b>LIN02</b>	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN**N4*01234567891~
2410	<b>LIN03</b>	Product or Service ID	Enter the NDC	LIN**N4*01234567891~

Loop	Segment	Element Name	Information	Sample
2410	<b>CTP04</b>	Quantity	Enter quantity billed	CTP****2*UN~
2410	<b>CTP05-1</b>	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit ME: Milligram	CTP****2*UN~
2410	<b>REF01</b>	Reference ID Qualifier (used to report Prescription # <b>or</b> Link Sequence Number when reporting components for a Compound Drug)	VY: Link Sequence Number XZ : Prescription Number	REF01*XZ*123456~
2410	<b>REF02</b>	Reference Identification	Prescription Number <b>or</b> Link Sequence Number	REF01*XZ*123456~

CMS 1500 Claim Form:

- Reporting the NDC requires using the upper **and** lower rows on a Claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- **DO NOT bill more than one NDC per Claim line.**
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a CMS-1500 Claim form. **All Elements are REQUIRED:**

How	Example	Where
Enter a valid NDC code including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in the <b>shaded area</b> of box 24A
Enter one of five (5) units of measure qualifiers; F2 – International Unit	GR0.045 ML1.0 UN1.000	In the <b>shaded area</b> immediately following the 11-digit NDC, enter 3 spaces, followed by one

How	Example	Where
GR – Gram ML – Milliliter UN – Units ME – Milligrams and quantity, <b>including a decimal point for correct reporting</b>		of five (5) units of measure qualifiers, followed immediately by the quantity
Enter a valid HCPCS or CPT code	J0610 “Injection Calcium Gluconate, per 10 ml” is billed as 1 unit for each 10 ml ampul used	<b>Non-shaded area</b> of box 24D

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	K. SUPPLIER INFORMATION
From MM DD YY	To MM DD YY	EMG	MODIFIER										
1											NPI		
2											NPI		
3											NPI		
4											NPI		
5											NPI		

Enter NDC in shaded area of box 24A

#### UB04 Claim Form:

- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB04 Claim form. **All Elements are REQUIRED:**

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42
Enter 11- digit NDC, including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in locator (box) 43 currently labeled as “Description”
Enter one of five (5) units of measure qualifiers; F2 – International Unit	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units

GR - Gram

ML - Milliliter

UN – Units

ME - Milligrams

and quantity, **including a decimal point for correct reporting**

of measure qualifiers, followed immediately by the quantity.

Enter a valid HCPCS or CPT Code

J0610 “injection Calcium, per 10ML” is billed as 1 unit for each 10ML ampul used

Form locator (box 44)

### Sample Images of the UB04 Claim Form

42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						0:00	1	
2						0:00	2	
3						0:00	3	
4								4
5								5

42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	N4##### GR0.045	J####	MMDDYY	1	##.##	0:00	1

## PAPER CLAIMS SUBMISSIONS

If Providers or Facilities must file Claims on paper, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at [www.cms.gov](http://www.cms.gov).

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.

- Submit a valid Member identification number including three digit prefix or R+8 numeric for Federal Employee Program® (FEP®) Members on all pages.
- Claims must be submitted with complete Provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

**Recommended CMS Form 1500 (02-12) Claim Fields** A sample form is available on the [CMS website](#).

<b>Field 1a:</b>	Insured's ID Number – from Member ID card, including any prefix
<b>Field 2:</b>	Patient's Name – do not use nicknames or middle names
<b>Field 3:</b>	Patient's Birth Date – date of birth should be 8-digit (MM DD YYYY) format and Sex
<b>Field 4:</b>	Insured's Name – “same” is acceptable if the insured is the patient
<b>Field 5:</b>	Patient's Address – submitted when the patient's address is different than the insured's address. If it's the same, this field does not need to be populated.
<b>Field 6:</b>	Patient Relationship to Insured
<b>Field 7:</b>	Insured's Address
<b>Field 10:</b>	Is Patient's Condition Related to:
<b>Field 10A:</b>	Employment?
<b>Field 10B:</b>	Auto Accident?
<b>Field 10C:</b>	Other Accident?
<b>Field 12:</b>	Patient Authorization Signature – If patient signature is on file, “Signature on file” is acceptable

**Important information about Fields 14 and 15:**

CMS Form 1500 (02-12) gives Providers and Facilities two fields (14 and 15) to enter a date with a “Qualifier” that tells payers what the date is for. Field 14 is titled “Date of Current Illness, **Injury**, or Pregnancy” and field 15 is titled “Other Date”. If the visit is due to an accident, Qualifier “439” must be entered in field 15 along with the appropriate date. This information is consistent with the form instruction manual available on the NUCC website. For more guidance, visit the NUCC website at [www.nucc.org](http://www.nucc.org).

<b>Field 14:</b>	<p>Date of Current Illness, Injury or Pregnancy (LMP) (if applicable) – Enter the 8-digit (MM DD YYYY) date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported:</p> <ul style="list-style-type: none"> <li>• 431 – Onset of current symptoms or illness</li> <li>• 484 – Last Menstrual Period</li> </ul>
<b>Field 15:</b>	<p>Other Date – Enter another date related to the patient’s condition or treatment. Enter the date in the 8-digit (MM DD YYYY) format. Enter the applicable qualifier to identify which date is being reported:</p> <ul style="list-style-type: none"> <li>• 454 – Initial treatment</li> <li>• 304 – Latest visit or consultation</li> <li>• 453 – Acute manifestation or a chronic condition</li> <li>• 439 – Accident</li> <li>• 455 – Last X-ray</li> <li>• 471 – Prescription</li> <li>• 090 – Report start (assumed care date)</li> <li>• 091 – Report end (relinquished care date)</li> <li>• 444 – First visit or consultation</li> </ul>
<b>Field 16:</b>	Dates Patient Unable to Work in Current Occupation – This is the time span a patient is or was unable to work
<b>Field 17:</b>	<p>Enter the name of the referring, supervising or ordering Provider.  <b>Enter the applicable qualifier to the left of the vertical, dotted line:</b></p> <ul style="list-style-type: none"> <li>• DN – Referring Provider</li> <li>• DK – Ordering Provider</li> <li>• DQ – Supervising Provider</li> </ul>
<b>Field 17b:</b>	Referring, ordering or supervising physician NPI
<b>Field 21:</b>	Diagnosis or Nature of Illness or Injury – enter the appropriate diagnosis code/nomenclature – Relate A-L to Field 24E
<b>Field 21:</b>	ICD Ind - ICD Indicator must be submitted between the vertical, dotted lines in the upper right-hand portion of the field or Claim may be rejected. Enter “9” for Code Set ICD-9-CM diagnosis for dates of service prior to 10/01/2015 or “0” for Code Set ICD-10 diagnosis for dates of service 10/01/2015 and later.
<b>Field 22:</b>	Resubmission and/or Original Reference Number – <b>This field is not intended for original Claim submissions.</b> When resubmitting a Claim, enter the original Anthem Claim number and the appropriate bill frequency code (7=Replacement of prior Claim; 8=Void/Cancel of prior Claim) left justified in the left-hand side of the field.



<b>Field 23:</b>	<p><b>Ambulance Providers:</b> Consistent with guidance from the Centers for Medicare and Medicaid Services (CMS), include the zip code for the point of pick up. Providers or Facilities can report the physical pick up and drop off addresses in field 32.</p> <p><b>Claims for Laboratory Services:</b> Include the CLIA number on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA.</p>
<b>Field 24:</b>	NDC - When submitting an NDC the NDC should be submitted in the shaded area and should be preceded with the qualifier N4, followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), ME (milligram) or ML (milliliter) number. The total dosage administered in mes or mls can be reported in box 24 (the shaded section) and should not be reported in the Units field. The Units field on the CMS-Form 1500 (02-12) box 24G represents the number of units based on the NDC number.
<b>Field 24a:</b>	Date(s) of Service
<b>Field 24b:</b>	Place of Service
<b>Field 24d:</b>	Procedures, Services or Supplies – Enter the appropriate CPT, HCPCS code/nomenclature; include a narrative description for Non Specific (NOC) codes. Do not use NOC codes when a specific CPT code is available. Anthem must have a clear description of the item/service billed with a NOC code to review. Descriptions should be included in the shaded area for item 24 on professional Claim forms. Indicate appropriate modifier when applicable.
<b>Field 24e:</b>	Diagnosis Pointer – refer to field 21 - Be sure to enter the diagnosis code reference (pointer) from Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The references were changed from numeric to alpha characters on the updated 02/12 form version. <b>Be sure to use alpha characters (A-L) and not numerics in this field.</b>
<b>Field 24f:</b>	\$ Charges – line item charge.
<b>Field 24g:</b>	Days or Units – When providing anesthesia submit time in minutes. When providing pain management, drugs, etc. it should be submitted in units.

<b>Field 24J:</b>	Lower: National Provider Identification number (NPI)
<b>Field 25:</b>	Federal Tax ID Number (9-digit)
<b>Field 28:</b>	Total Charge – total of line item charges.
<b>ToField 31:</b>	Full name and title of Physician or Supplier – actual signature or typed/printed designation is acceptable.
<b>Field 32:</b>	Service Facility Location Information – Address where services were rendered
<b>Field 32a:</b>	Service Facility's National Provider Identification number (NPI) – Service location NPI
<b>Field 33:</b>	Billing Provider Information and Phone # – Complete name, address, city, state and zip code
<b>Field 33a:</b>	Billing Provider's National Provider Identification number (NPI) – Billing Provider NPI

Reminder: If submitting Claims electronically, field 33 must hold a physical address and should not contain any of the following: "Post Office Box", "P.O. Box", "PO Box", "Lock Box", "Lock Bin", "PO Box"

Note: To help improve payment accuracy and timeliness, remember that when filing Claims, the Tax Identification Number (TIN) and National Provider Identifier (NPI) numbers are required. Additionally, bill Claims using the taxonomy codes as applicable.

#### **Recommended UB-04 (CMS-1450) Claim Fields**

If these fields are not completed, Claims may be delayed or returned to the Provider or Facility for additional information. A sample form is available on the [CMS website](#).

<b>Field 1:</b>	Provider name and complete address
<b>Field 2:</b>	Provider's designated billing name and remittance address
<b>Field 4:</b>	Type of Bill
<b>Field 5:</b>	Federal Tax Identification Number
<b>Field 6:</b>	Statement Covers Period (From-Through)
<b>Field 8:</b>	Patient Name
<b>Field 9:</b>	Patient Address

<b>Field 10:</b>	Birth Date (8-digit (MM DD YYYY) format)
<b>Field 11:</b>	Sex
<b>Field 12:</b>	Admission Date
<b>Field 13:</b>	Admission Hour
<b>Field 14:</b>	Admission Type – Priority (Type) of Admission or Visit [Inpatient only]
<b>Field 15:</b>	Admission SRC – Point of Origin for Admission or Visit [Inpatient only]
<b>Field 16:</b>	Discharge Hour [Inpatient only]
<b>Field 17:</b>	Patient Discharge Status [Inpatient only]
<b>Fields 31-34:</b>	Occurrence Codes and Dates
<b>Fields 39-41:</b>	Value Code(s) and Amounts

- If there is a Combined Deductible + Coinsurance + Copay amount on the EOMB greater than zero, there must be a corresponding Value code of A1, B1, C1, 08, 09, 11, A2, B2, C2 A7, B7 or C7 and amount on the UB04.
- If there is a Value Code present and not equal to 02 there must be a Value Code amount.
- The Value Codes to be submitted when billing Private Room Revenue codes according to the UB-04 Data Specifications Manual 2014 and CMS Manual Transmittal 1104 are:
  - “01” (semi-private room Facility) must be accompanied by the semi-private room rate when the Facility offers semi-private rooms and the patient’s stay is in a private room
  - “02” indicating “private room only” Facility with \$0.00 when the Facility is private room only

#### Common errors in Fields 39-41:

The following is a quick overview of the most common errors Anthem sees on fields 39, 40 and 41, when Medicare is primary and Anthem is secondary:

- **Value codes are missing.** Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.
- **The Member deductible is missing or does not match the EOMB (Explanation of Medicare Benefits).** If there is a deductible amount indicated on the primary payer’s remittance advice, the UB04 must include the Member deductible (A1, B1 or C1 value code) and amount.
- **The coinsurance amount is missing.** If there is coinsurance on the primary payer’s remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).

- **The copay amount is missing.** If there is copayment on the primary payer's remittance advice, the UB04 must include the copay amount (A7, B7, or C7 value code).
- **Blood deductible is not noted.** If there is blood deductible on the payer's remittance advice, the value code 06 must be on the Claim, along with the amount.
- **There are errors in listing multiple value codes.** If more than one value code is submitted on lines a – d, fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.
- **The value code and remittance advice amounts are different.** In all cases, the value code and remittance advice amounts must match.

<b>Field 42:</b>	Revenue Code(s) – When submitting Revenue Code 011X or 11X and/or 014X or 14X, (X = numeric value) a value code of 01 with an amount greater than zero OR a value code of 02 with zero charges or blank must also be submitted.
<b>Field 43:</b>	Description – <b>NDC:</b> When submitting an unlisted drug HCPCS code, submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), ME (milligram) or ML (milliliter). The total dosage administered in mes or mls can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number.
<b>Field 44:</b>	HCPCS/Accommodation Rates/HIPPS Rate Codes
<b>Field 45:</b>	Service Date
<b>Field 46:</b>	Service Units
<b>Field 47:</b>	Total Charges
<b>Field 56:</b>	Providers National Provider Identification number (NPI)
<b>Field 58:</b>	Insured's Name
<b>Field 59:</b>	Patient's Relationship
<b>Field 60:</b>	Insured Unique ID – from Member ID card, including any prefix/suffix
<b>Field 66:</b>	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) – The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 -Ninth Revision for dates of service prior to 10/01/2015 or 0 -Tenth Revision for dates of service 10/01/2015 and later.
<b>Field 67:</b>	Principal Diagnosis Code and Present on Admission (POA) Indicator

**Fields 67A-Q:**

Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s)

**Field 74:**

Principal Procedure Code and Date

## MEDICAL RECORDS SUBMISSION (SOLICITED AND UNSOLICITED)

### Solicited Medical Records Submission

When additional medical records are being submitted in response to Anthem's request, the recommended method is to submit them electronically via Availity using the Medical Attachments tool following the directions below. The Medical Attachments tool supports .tiff, .jpg and pdf attachment file types. Providers should submit medical records within ten days of Anthem's request.

A Provider organization's Availity administrator should complete the following set-up steps to authorize user access to the Medical Attachments tool:

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

1. Select Application > Choose **Medical Attachments Registration**
2. Provider Management > Select **Organization** from the drop-down.
  - Add NPIs and/or Tax IDs. (both are recommended)
  - Multiples can be added separated by spaces or semi-colons.
3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.

To submit supporting documentation in response to a solicited request:

- Login to Availity portal
- Select **Claims & Payments > Attachments – New**
- Select **Send Attachment**
- Under the **Request for Information**, select **Yes, if this is a response to a request from a health plan or a need to submit documentation for a specific Claim number**
- Add supporting documentation and Reason
- Submit

If Availity set-up has not been completed and medical records must be sent via mail or fax, send them to the appropriate department as directed in the notification from Anthem. **Always include a copy of the request letter on top of the records. Do not** place a copy of the Claim on top of the records.

- If Providers or Facilities are submitting X-Rays, pictures or dental molds, remember to include a valid and complete Member identification number on page one of the material sent with these items.

### Unsolicited Medical Records Submission

Anthem will send a request when medical records are required. However, if a Provider or Facility wishes to send medical records with the Claim submission, below are helpful tips to follow.

To determine what medical records or portion of the medical records may be required, refer to the applicable Anthem Medical Policy, Anthem Clinical Guideline, [AIM Clinical Guideline or MCG](#) at [www.anthem.com](http://www.anthem.com). Review the Position Statement section of the Anthem Medical Policies or the Clinical Indications section of the applicable Anthem or AIM Clinical Guidelines, to determine what medical records are needed. Refer to the *Medical Policies*, *Clinical Guidelines*, and/or *AIM Specialty Health* sections of the Provider Manual for details on accessing this information.

When submitting medical records that are not requested by Anthem, include a clear description of the billed code submitted with the Claim to help ensure prompt processing of the Claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

Providers and Facilities can now submit unsolicited medical records using the Availity Portal

A Provider organization's Availity administrator should complete the set-up steps listed above in Solicited Medical Records Submission section to authorize user access to the Medical Attachments tool.

Submit an EDI 837 batch, which includes a PWK segment in loops 2300/2400; this detail is the linkage between the electronic Claim and the supplemental documentation.

- Log in to Availity portal
- Select **Claims & Payments > Attachments - New**
- From the **Inbox** tab, select the appropriate Claim
- Add files with supporting documentation
- Submit

### Types of Medical Records Required

Medical records needed to determine the medical necessity of a billed code include but are not limited to, depending on the service or procedure, some or all of the following examples:

- History & Physical, Office Notes, Treatment Records & Response
- Chemotherapy Regimens, Chemotherapy Drugs, and Records
- Medications List (current and prior)
- Radiology, Diagnostic Imaging, or Diagnostic Testing Reports
- Therapy/Rehabilitation Records
- Laboratory reports, Pathology reports
- Exact description of NOC/NOS code
- Operative/Procedure Report
- Inpatient Admission Summary, Daily Records, Discharge Summary

### Anthem May Request Additional Records

Some situations may require additional medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, Anthem will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but are not limited to, the following situations:

- Medical records requested by a Member's Blue Cross and/or Blue Shield home plan
- Federal Employee Health Benefits Program requirements

- Review and investigation of Claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)
- Medical review and evaluation
- Requests for retro authorizations
- Medical management review (utilization review) and evaluation
- Underwriting review and evaluation
- Adjustments
- Appeals
- Quality management (quality of care concerns)
- Records documenting prolonged services
- Provider audits
- Pre-pay review program
- Fraud, waste and abuse

### **HIPAA Privacy Rule – Minimum Necessary**

Anthem complies with HIPAA Privacy Rules and will request the minimum necessary information needed to determine benefits and/or coverage associated with Claim processing. Providers and Facilities are also required under the Minimum Necessary rule to submit only those records requested.

## **ELECTRONIC DATA INTERCHANGE (EDI)**

Anthem uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835), and Electronic Funds Transfers (EFT) allows for a faster, more efficient and cost-effective way for Providers to do business.

### **Advantages of Electronic Data Interchange (EDI)**

- Process Claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper Claim submissions

### **Use Availity for the following EDI transactions**

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

### **Ways Providers and Facilities can use the Availity EDI Gateway**

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Use the Provider or Facility's existing clearinghouse or billing vendor to ensure connection to the Availity EDI Gateway



## Electronic Data Interchange Trading Partner

Trading partners connect with Availity's EDI gateway to send and receive EDI transmissions. A Trading Partner can be a Provider organization using software to submit direct transmissions, billing company or a clearinghouse vendor.

To become an EDI Trading Partner visit [www.availity.com](http://www.availity.com).

Select Login if already an Availity user, choose My Providers < Transaction Enrollment or choose Register if new to Availity.

## Payer IDs

Payer IDs route EDI transactions to the appropriate payer. The [Availity Payer ID list](#) is available on the Availity Portal. If a Provider or Facility uses a clearinghouse, billing service or vendor, work with them directly to determine payer ID.

## Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

To register or manage Electronic Funds Transfer (EFT):

Go to [anthem.com/provider/edi](http://anthem.com/provider/edi) > Select State > EDI Resources > Select Electronic Funds Transfer

## Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

Log in to [Availity](#) > Select **My Providers** > Select **Enrollment Center** > Select **Transaction Enrollment**

**Note:** *If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.*

## Contact Availity

Contact Availity Client Services with any questions at 1-800-Availity (282-4548)

## Useful EDI Documentation

- [Availity EDI Connection Service Startup Guide](#) - This guide includes information to get started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
- [Availity EDI Companion Guide](#) - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
- [Availity Registration Page](#) - Availity register page for users new to Availity.
- [Washington Publishing Company](#) - X12 code descriptions used on EDI transactions



## OVERPAYMENTS

Anthem's Cost Containment Overpayment Avoidance Division reviews Claims for accuracy and requests refunds if Claims are overpaid or paid in error. Some common reasons for overpayment are:

- Paid wrong Provider/Member
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate
- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid
- Paid wrong Member/ Provider number

Anthem's Cost Containment Overpayment Avoidance Division also requests refunds for overpayments identified by other Divisions of Anthem, such as Provider Audit or the Special Investigations Unit.

### **Anthem Identified Overpayment (aka "Solicited")**

When refunding Anthem on a Claim overpayment that Anthem has requested, use the payment coupon included on the request letter and the following information with the check:

- **The payment coupon**
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the refund request letter

As indicated in the Anthem refund request letter and in accordance with Provider contractual language, Provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment from any Claim Provider or Facility submits to Anthem.

Providers and Facilities may direct disputes of amounts indicated on an Anthem refund request letter to the address indicated on the letter.

### **Provider and Facility Identified Overpayments (aka "voluntary" or "unsolicited")**

If Anthem is due a refund as a result of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

- Submit a refund check with supporting documentation outlined below, or
- Submit the **Provider Refund Adjustment Request Form** with supporting documentation to have Claim adjustment/recoupment done off a future remittance advice

When voluntarily refunding Anthem on a Claim overpayment, include the following information:

- **Provider Refund Adjustment Request Form (see directions below for how to access online)**

- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

Ensure the copy of the Provider remittance advice is legible and the Member information that relates to the refund is circled. By providing this critical information, Anthem will be able to expedite the process, resulting in improved service and timeliness to Providers and Facilities.

**Note:** *If a Provider or Facility is refunding Anthem due to coordination of benefits and the Provider or Facility believes Anthem is the secondary payer, **refund the full amount paid**. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.*

To download the "Provider Adjustment Form" directly from **anthem.com**, select **Providers** from the horizontal menu. On the Provider landing page, choose **Find Forms**, and then select the **Provider Refund Request Form**.

**Utilize the proper address noted in the grid below to return payment:**

Make Check Payable To:	Regular Mailing Address:	Overnight Delivery Address:
Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield P.O. Box 73651 Cleveland, OH 44193-1177	Anthem Blue Cross and Blue Shield Lockbox 73651 4100 West 150th Street Cleveland, Ohio 44135

## MEDICARE CROSSOVER

### Duplicate Claims Handling for Medicare Crossover

All Blue Plans are required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims to the Blue secondary payer to eliminate the need for Provider or Facilities or his/her/its billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

When a Medicare Claim has crossed over, Providers and Facilities are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Member's Blue Plan.

To avoid the submissions of duplicate Claims, use the 276/277 Health care Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

The Claims Providers and Facilities submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process

may take approximately 14 days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for Providers or Facilities to receive payment or instructions from the Blue Plan.

Providers and Facilities should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit Claims to Medicare to allow for the crossover process to occur and for the Member's benefit policy to be applied.

Medicare primary Claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by the local Plan.

Anthem will reject Medicare primary Provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within 30 calendar days of Medicare remittance date
- Received by Provider or Facility's local Plan with no Medicare remittance date
- Received with GY modifier on some lines but not all
  - A GY modifier is used by Providers and outpatient Facilities when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of Claims are rejected, Anthem will also remind the Provider or Facility to allow 30 days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

### **Medicare statutorily excluded services – just file once to the local Plan**

There are certain types of services that Medicare never or seldom covers, but a secondary payer such as Anthem may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, Providers and outpatient Facilities need only file statutorily excluded services directly to their local Plan using the GY modifier and will no longer have to submit to Medicare for consideration. These services must be billed with only statutorily excluded services on the Claim and will not be accepted with some lines containing the GY modifier and some lines without.

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers and Facilities can expect the Member's benefit plan to reject the Claim advising the Provider or Facility to submit to their local Plan when the services rendered are

considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to a Provider or Facility's local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider's or Facility's contractual Agreement.

- Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
- Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
- The Provider or outpatient Facility's local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to their local Plan, the Provider or outpatient Facility's local Plan will deny the Claims, instructing the Provider or outpatient Facility to split the Claim and resubmit.

**Original Medicare** – The GY modifier *should* be used when service is being rendered to a Medicare primary Member for statutorily excluded service and the Member has Blue secondary coverage, such as an Anthem Medicare Supplement plan. The value in the SBR01 field should not be "P" to denote primary.

**Medicare Advantage** – Ensure SBR01 denotes "P" for primary payer within the 837 electronic Claim file. This helps ensure accurate processing on Claims submitted with a GY modifier.

**The GY modifier *should not* be used when submitting:**

- Federal Employee Program Claims
- Inpatient institutional Claims. Use the appropriate condition code to denote statutorily excluded services.

These processes align Blue Cross and/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, Members will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Member.

**Medicare Crossover Claims FAQs**

**1. How do Providers and Facilities handle traditional Medicare-related Claims?**

- When Medicare is primary payer, submit Claims to the local Medicare intermediary.
- All Blue Claims are set up to automatically cross over (or forward) to the Member's Blue Plan after being adjudicated by the Medicare intermediary.

**2. How do Providers and Facilities submit Medicare primary / Blue Plan secondary Claims?**

- For Members with Medicare primary coverage and Blue Plan secondary coverage, submit Claims to the Medicare intermediary and/or Medicare carrier.
- When submitting the Claim, it is essential that Providers and Facilities enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Member's ID card for additional verification.
- Be certain to include the three-character prefix as part of the Member identification number. The Member's ID will include the three-character prefix in the first three positions. The three-character prefix is critical for confirming Membership and coverage, and key to facilitating prompt payments.

***When Providers and Facilities receive the remittance advice from the Medicare intermediary, look to see if the Claim has been automatically forwarded (crossed over) to the Blue Plan:***

- If the remittance advice indicates that the Claim was crossed over, Medicare has forwarded the Claim on behalf of the Provider or Facility to the appropriate Blue Plan and the Claim is in process. **DO NOT** resubmit that Claim to Anthem; duplicate Claims will result in processing and payment delays.
- If the remittance advice indicates that the Claim was not crossed over, submit the Claim to the local Anthem Plan with the Medicare remittance advice.
- In some cases, the Member identification card may contain a COBA ID number. If so, be certain to include that number on the Claim.
- For Claim status inquiries, contact the local Anthem Plan.

### **3. Who do Providers and Facilities contact with Claims questions?**

- The local Anthem Plan.

### **4. How do Providers and Facilities handle calls from Members and others with Claims questions?**

- If Members contacts a Provider or Facility, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
- A Member's Blue Plan should not contact Providers or Facilities directly, unless a paper Claim was filed directly with that Blue Plan. If the Member's Blue Plan contacts the Provider or Facility to send another copy of the Member's Claim, refer the Blue Plan to the local Anthem Plan.

### **5. Where can Providers and Facilities find more information?**

For more information:

- Visit Anthem's Web site at [www.anthem.com](http://www.anthem.com) or
- Contact the local Anthem Plan.

# Claim Payment Disputes

## PROVIDER AND FACILITY CLAIM PAYMENT DISPUTE PROCESS

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Anthem Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome.

There are three common, Claim-related issues that are **not** considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, they are defined briefly here:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can Chat with Payer or send a Secure Message through the Availity Portal. If Providers or Facilities are unable to utilize the Availity Portal for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference the *Availity Portal* section in this Manual.
- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (“EOP”) The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.
- **Clinical / Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, refer to the *Clinical Appeals* section within the Provider Manual.

Reference the *Claims Submission Filing Tips* section for additional information.

The Anthem Claim Payment Dispute process consists of two steps. Providers and Facilities will **not** be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

1. **Claim Payment Reconsideration:** This is the first step in the Anthem Claim Payment Dispute process. The Claim Payment Reconsideration represents the Provider or Facilities initial request for an investigation into the outcome of the Claim. Most issues are resolved at the Claim Payment Reconsideration step.
2. **Claim Payment Appeal:** This is the second step in the Anthem Claim Payment Dispute process. If a Provider or Facility disagrees with the outcome of the Claim Payment Reconsideration, Providers or Facilities may request an additional review as a Claim Payment Appeal.

A Claim Payment Dispute may be submitted for multiple reason(s), including:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims

- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim Payment Dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues\*
- Disputes of Prepayment Itemized Bill Review Findings.

\* Anthem will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements or 2) demonstrate good cause exists. See “Timely Filing for Claims” and “Proof of Timely Filing” in the Claims Filing Tips section of the Manual for more information.

## **CLAIM PAYMENT RECONSIDERATION**

The first step in the Anthem Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facilities initial request to investigate the outcome of a finalized Claim. Anthem cannot process a Claim Payment Reconsideration without a finalized Claim on file.

Claim Payment Reconsiderations can be submitted via phone, the web portal, or in writing. Providers and Facilities have a minimum of 12 months from the issue date of the EOP (or such other period as set forth in their Provider or Facility Agreement.)

A determination will be made and the initial payment on the Claim will either be upheld or overturned. If the Provider or Facility is satisfied with this determination, the process will end. If the Provider or Facility disagrees with the determination of the Reconsideration, they can file a second request, called a Claim Payment Appeal.

When submitting Claim Payment Reconsiderations, Providers and Facilities should include as much information as possible to help Anthem understand why the Provider or Facility believes the Claim was not paid as expected. If a Claim Payment Reconsideration requires clinical expertise, it will be reviewed by the appropriate Anthem clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

## **CLAIM PAYMENT APPEAL**

If a Provider or Facility is dissatisfied with the outcome of a Claim Payment Reconsideration determination, Providers and Facilities may submit a Claim Payment Appeal through Availity or in writing. Providers and Facilities should submit a Claim Payment Reconsideration before submitting a Claim Payment Appeal. Providers and Facilities are encouraged to submit Claims Payment Appeals within 30 days from the date of the determination of the Claims Payment Reconsideration.

When submitting a Claim Payment Appeal, Providers and Facilities should include as much information as possible to help Anthem understand why the Provider or Facility believes the Claim



Payment Reconsideration determination was in error. If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate Anthem clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

## **REQUIRED DOCUMENTATION FOR CLAIMS PAYMENT DISPUTES**

Anthem requires the following information when submitting a Claim Payment Dispute (Claim Payment Reconsideration or Claim Payment Appeal):

- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and Anthem ID number
- A listing of disputed Claims, which should include the Anthem Claim number and the date(s) of service(s)
- All supporting statements and documentation

### **How to Submit a Claim Payment Dispute**

- There are several options to file a Claim Payment Dispute:
  - Online through the Availity
  - Mail all required documentation to:  
Anthem Claim Payment Dispute  
P.O. Box 105449  
Atlanta, GA. 30328-5449
- Call the number on the back of the Member ID Card

--Note: Correspondence received from Anthem related to the Claims Payment Dispute Process may not reflect all the nomenclature outlined in this section at this time. Providers and Facilities will continue to receive the same correspondence that has been received related to these requests as they have in the past.

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## **Clinical Appeals**

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Clinical appeals refer to a situation in which an authorization or Claim for a service was denied as not medically necessary or experimental/investigational. Medical necessity appeals/prior authorization appeals are different than Claim Payment Disputes and should be submitted in accordance with the Clinical appeal process.

For questions regarding non-clinical decisions, refer to the Claim Payment Dispute section. Examples of non-clinical items that fall under Claim Payment Disputes include:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues



- Claims that are denied for no authorization when an authorization was obtained, a Claim dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues
- Disputes of Prepayment Itemized Bill Review Findings.

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- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues

Clinical Appeals can be used if Providers or Facilities disagree with a clinical decisions. Clinical Appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/ investigative. UM program Clinical Appeals involve certification decisions, Claims, or predetermination decisions evaluated on these bases. Clinical Appeals can be made verbally, in writing, or by using Interactive Care Reviewer for appeals regarding prior authorization adverse decision.

Anthem Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Provider Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to Anthem's Member Complaint and Appeal Procedures, for each applicable state. Provider Customer Service will help Providers and Facilities determine what action must be taken and if a Designation Of An Authorized Representative form is needed. The Designation Of An Authorized Representative form ("DOR") form can be found online at [anthem.com](https://www.anthem.com). Select **Providers**, Select **Forms and Guides** (under the Provider Resources column), if needed use the **Change/Select State** link at the top right. Scroll down and select **Forms and Guides**, then scroll down and select **Claims & Appeals** in the Category drop down and select **Designation of an Authorized Representative (DOR)**.

### Guidelines and Timeframes for Submitting Clinical Appeals

- Providers and Facilities have one hundred and eighty (180) calendar days to file a clinical appeal from the date they receive notice of Anthem's initial decision.

- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Anthem.
- For clinical appeals, there are two (2) types of review: expedited and standard.
  - *Expedited Appeal:* Anthem offers an expedited appeal for decisions meeting the expedited criteria. Requests to handle a review as “expedited” are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member’s designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Anthem Member Appeal Procedures exclusively.
  - *Standard Appeal:* A standard appeal is available following the reconsideration, or initially, if it is formally requested.
- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.

Note: Requests for appeal of Pre-Service requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. Detailed instructions are included in the UM decision letter.

- Appeals should be submitted to Anthem, along with a copy of the response to the original complaint. Send the appeal request to:

Anthem Blue Cross and Blue Shield  
 Attention: Grievances and Appeals  
 P.O. Box 105568  
 Atlanta, GA 30348-5568

### **BlueCard® Members**

Appeals involving clinical decisions related to Medical Necessity, experimental/investigative and/or Utilization Management (UM) decisions involving Pre-certification/Pre-authorization are the responsibility of the Blue Plan insuring or administering benefits for non-Anthem Members (the Member’s Home Plan).

Technically the Member, not the Provider or Facility, is responsible for obtaining the necessary authorization prior to the delivery of non-inpatient admission services. Providers must obtain the necessary authorization prior to the delivery of inpatient admission services. Failure to obtain the necessary authorization may result in non-payment or penalty reduction to the Provider Anthem understands that many Providers obtain Pre-certification/Pre-authorization or may wish to dispute these types of denials on behalf of, and as a service to, their patients.

- If the appeal relates to Pre-certification/Pre-authorization, the Provider or Facility may have received information directly from the Member's Home Plan regarding appeal rights and processes. Follow the directions provided by the Member's Home Plan.
- If the appeal relates to Claim denial, and the Provider or Facility did not receive this information from the Member's Home Plan and wishes to appeal a Medical Necessity or experimental/investigational Claim denial, the local Anthem Plan is the point of contact. When a Provider or Facility expresses dissatisfaction and wishes to file an appeal as indicated in the description above, a Claim Payment Dispute should be submitted, along with attached supporting documentation, to the local Anthem Plan. Reference the Claim Payment Dispute section for further details.
- Providers submitting an appeal on behalf of the Member may be required to submit a Member authorization form.

## Member Quality of Care/Quality of Service Investigations

### OVERVIEW

The Grievances and Appeals department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service ("QOC"/"QOS") concerns or sentinel events involving Anthem Members. This includes cases reviewed as the result of a grievance submitted by a Member and potential quality issues ("PQI") reviewed as the result of a referral received from an Anthem clinical associate. All Anthem associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and/or Facility are requested. If the clinical associate determines the case is a non-issue with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. A clinical associate may issue a C-3 rating for a Provider's or Facility's failure to submit requested information. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a Member grievance, the Member is sent a resolution letter within thirty (30) calendar days of Anthem's receipt of the grievance. The Member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

Significant quality of care issues may be elevated to the regional Peer Review Committee for Second Level Peer Review. This may result in a subsequent referral to the appropriate Credentials Committee.

Trends/patterns of all assigned severity levels are reviewed with the Medical Director for intervention and corrective action planning.

Providers and Facilities have a contractual obligation to actively cooperate with any investigation. When a Member alerts Anthem to a quality concern regarding the care they received, Anthem has an obligation to thoroughly investigate that allegation by reviewing all relevant materials including any internal investigation and their outcomes done by the impacted Providers and/or Facility. This requirement is in the Provider and Facility Agreements and, as a business associate, Anthem has a right to that information.

## **CORRECTIVE ACTION PLANS (“CAP”)**

When corrective action is required, the Medical Director or the applicable local Peer Review Committee will determine appropriate follow-up interventions which can include one or more of the following: a CAP from the Provider and/or Facility, CME, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to the appropriate committee.

## **REPORTING**

G&A leadership reports grievance and PQI rates, categories, and trends; to the appropriate Quality Improvement Committee on a bi-annual basis or more often as appropriate. Quality improvement or educational opportunities are reported, and corrective measures implemented, as applicable. Results of corrective actions are reported to the Committee. The Quality Council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

## **SEVERITY LEVELS FOR QUALITY ASSURANCE**

Quality of Care		
Level	Points Assigned	Description
C-0	0	No quality of care issue found to exist.
C-1	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.
C-2	5	Communication, administrative, or documentation issue that adversely affected the care rendered.
C-3	5	Failure of a practitioner/Provider to respond to a Member grievance regarding a clinical issue despite two requests per internal guidelines.
C-4	10	Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.
C-5	15	Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.

Quality of Care		
C-6	25	Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.

Quality of Service		
Level	Points Assigned	Description
S-0	0	No quality of service or administrative issue found to exist.
S-1	0	Member grievances regarding practitioner's office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space.
S-2	5	Communication, administrative, or documentation issue with no adverse medical effect on Member.
S-3	5	Failure of a practitioner/Provider to respond to a Member grievance despite two requests per internal guidelines.
S-4	10	Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.

## TREND THRESHOLD FOR ANALYSIS

### Quality of Care and Service Trend Parameters

The following accumulation of QOC and QOS cases with severity levels and points, or any combination of cases totaling 20 points or more during a rolling 12 months will be subject to trend analysis:

- 8 cases with a leveling of C-0 and S-0
- 4 cases with a leveling of C-1
- 4 cases with a leveling of C-2 and S-2
- 4 cases with a leveling of C-3 and S-3
- 2 cases with a leveling of C-4
- 2 cases with a leveling of C-5
- 1 case with a leveling of C-6 (automatic referral to the applicable Peer Review Committee)
- 3 cases with a leveling of S-1 (for a specific office location in a 6 month period); refer for site visit
- 4 cases with a leveling of S-4 (automatic referral to the applicable Provider Review Committee)

A rolling 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitute a trend).

An analysis is completed by the G&A clinical associate and forwarded to the Medical Director to determine if there is a pattern among the cases. For example, a Provider who repeatedly fails to return phone calls to postoperative patients resulting in the potential for or an actual adverse outcome. The Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

Corrective action plans received for QOC issues are reviewed by the Medical Director and may be forwarded to the applicable local Peer Review Committee for further review and follow up, as appropriate.

**A Provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.**

## Reimbursement Requirements and Policies

This section includes reimbursement guidelines and policies on how Anthem will reimburse Providers and Facilities for certain services. Reimbursement Policies are published on anthem.com be sure to check both places. To locate the policies online go to **Anthem.com**, select **Provider**, choose **Policies, Guidelines and Manuals** under Provider Resources in the horizontal menu. Scroll down to **Reimbursement Policies** and select **Access policies**. Anthem reserves the right to review and revise policies when necessary.

### BLOOD, BLOOD PRODUCTS, AND ADMINISTRATION

Blood and blood products such as platelets or plasma are reimbursable. Transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are not reimbursable on inpatient Claims.

### CHANGES DURING ADMISSION

There are elements that could change during an admission. The following table shows the scenarios and the date to be used for the entire Claim:

CHANGE	EFFECTIVE DATE
Member's Insurance Coverage	Admission
Facility's Contracted Rate (other than DRG)	Admission
DRG Base Rate	Admission
DRG Grouper	Discharge
DRG Relative Weight	Discharge

CHANGE	EFFECTIVE DATE
CPT & HCPCS coding changes	Discharge

## **CODING REQUIREMENTS**

Providers and Facilities will submit Claims in a format consistent with industry standards and acceptable to Anthem.

## **COMPREHENSIVE HEALTH PLANNING**

Facility shall not bill Anthem, Plan or a Member for Health Services, expanded facilities, capital operating costs or any other matter of service requiring a certificate of need approval or exemption under existing law, or similar or successor laws that may be adopted from time to time, unless said approval or exemption has been granted in writing.

## **COURTESY ROOM**

Facility shall not bill Anthem, Plan, and/or Members for any charges related to use of a Courtesy Room in the provision of Health Services to a Member. "Courtesy Room" means an area in the Facility where a professional Provider is permitted by Facility to provide Health Services to Members.

## **DIFFERENT SETTINGS CHARGES**

If Anthem determines that Facility submits charges differently for the same service performed in a different setting, Anthem may reimburse at the Anthem Rate for the lesser of the two charges.

## **ELIGIBILITY AND PAYMENT**

A verification of eligibility is not a guarantee of payment.

## **EMERGENCY ROOM SUPPLIES AND SERVICES CHARGES**

The Emergency Room level reimbursement includes all monitoring, equipment, supply, time, and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

## **EVALUATION AND MANAGEMENT (E&M) SERVICES**

Prior to payment, Anthem may review E&M Claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E&M code level submitted is higher than the E&M code level supported on the Claim. If the E&M code level submitted is higher than the E&M code level supported on the Claim, Anthem reserves the right to:

- Deny the Claim and request resubmission of the Claim with the appropriate E&M level;
- Pend the Claim and request that the Facility or Provider submit documentation supporting the E&M level billed; and/or
- Adjust reimbursement to reflect the lower E&M level supported by the Claim



## **FACILITY PERSONNEL CHARGES**

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

## **GENERAL INDUSTRY STANDARD LANGUAGE**

Per Anthem policy and the Agreement, Provider and Facility will follow industry standards related to billing. Per the UB-04 and CMS1500 (or subsequent forms) billing manual referenced as Coded Service Identifier(s).

## **INSTRUMENT TRAYS**

Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. See Operating Room Time and Procedure Charges for additional information.

## **INTERIM BILL CLAIMS**

Anthem shall not adjudicate Claims submitted as interim bills for services reimbursed under DRG methodology.

## **IV SEDATION AND LOCAL ANESTHESIA**

Charges for IV Sedation and local anesthesia administered by the Provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room ("OR") time/procedure reimbursement.

## **LAB CHARGES**

Blood storage and processing, blood administration and thawing fees are inclusive of the procedure/lab test performed and not separately reimbursable.

## **LABOR CARE CHARGES**

Anthem will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG will not be reimbursed by Anthem for Outpatient Services rendered prior to the admission.

## **MEDICAL CARE PROVIDED TO OR BY FAMILY MEMBERS**

Services for any type of medical care rendered by a Provider to him/herself or to an immediate family Member (as defined below), who is a Member, are not eligible for coverage and should not be billed to Anthem. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his/her immediate family Member.

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family Member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.



## NURSING PROCEDURES

Anthem will not separately reimburse fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

## OPERATING ROOM TIME AND PROCEDURE CHARGES

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Linen packs, instrument packs, packs, post-op dressing, equipment and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire.

The operating room charge will not reflect the cost of robotic technology and is not eligible for separate reimbursement. Examples of charges that are not eligible for separate or additional reimbursement are listed below:

- Increased operating room unit cost charges for the use of the robotic technology
- Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to, S2900
- Supplies billed related to the use of robotic technology.
- Reference the [Robotic Surgical Systems](#) Reimbursement Policy.
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## OTHER AGREEMENTS

If Facility currently maintains a separate Agreement(s) with Anthem solely for the provision and payment of home health care services, skilled nursing Facility services, ambulatory surgical Facility services, or other Agreements that Anthem designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

## **PERSONAL CARE ITEMS**

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste. Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable. Examples include but are not limited to: bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

## **PHARMACY CHARGES**

Pharmacy charges will include the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Anthem will reimburse at the Anthem Rate for the drug. All other services are included in the Anthem Rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and Facility staff checking the pharmacy ("Rx") cart.

## **PORTABLE CHARGES**

Portable Charges are included in the reimbursement for the procedure, test or x-ray and are not separately reimbursable.

## **PRE-OPERATIVE CARE OR HOLDING ROOM CHARGES**

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure, and are not separately reimbursed. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

## **PREPARATION (SET-UP) CHARGES**

Charges for set-up, equipment or materials in preparation for procedures or tests are included in the reimbursement for that particular procedure or test.

## **PROVIDER AND FACILITY RECORDS**

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Members receiving Health Services. All of Provider's and Facility's records on Members shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

## **RECOVERY ROOM CHARGES**

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include, but is not limited to EKG monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

## **RECOVERY ROOM SERVICES RELATED TO IV SEDATION AND/OR LOCAL ANESTHESIA**

Anthem will not provide reimbursement for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) e.g. arteriograms. The Anthem Rate shall not exceed the Facility's approved average semi-private room and board rate less discount, as submitted to Anthem.

## **RESPIRATORY SERVICES**

More than one type of respiratory support (for example: mechanical ventilation and CPAP) at the same time and/or on the same day is not eligible for separate reimbursement, unless there is clinical documentation to support that the Member requires different levels of respiratory support. Mechanical Ventilation / CPAP / BIPAP support is inherent to ICU/CCU/NICU room & board care is not eligible for separate reimbursement.

## **ROUTINE SUPPLIES**

Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

## **SEMI PRIVATE ROOM RATE**

Anthem must be notified in writing of any changes, and new rates will be loaded thirty (30) days after such notification. No Claims will be reprocessed as a result of changes to semi-private room rates. All eligible charges for Covered Services will be limited to the approved average semi-private room and board rate, less discount, as submitted to Anthem.

## **SPECIAL PROCEDURE ROOM CHARGE**

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

## **STAND-BY CHARGES**

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Staff on standby is included in the reimbursement for the procedure and also is not separately reimbursable.

## **STAT CHARGES**

Stat charges are included in the reimbursement for the procedure, test and or X-ray. These charges are not separately reimbursable.

## **SUBMISSION OF CLAIM/ENCOUNTER DATA**

Facilities and Providers will submit Claims and encounter data to Anthem on a CMS-1500, UB04, or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Anthem. Anthem will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state

statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of Anthem's payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

## **SUPPLIES AND EQUIPMENT**

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable. Also, oxygen charges, including but not limited to, oxygen therapy per minute/per hour, mechanical ventilation and ventilation management, continuous positive airway pressure (CPAP), and bilevel positive airway pressure (BIPAP), when billed with room types ICU/CCU/NICU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

## **TECH SUPPORT CHARGES**

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

## **TELEMETRY**

Telemetry charges in ER/ICU/CCU/NICU or telemetry unit are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable. Separately billed telemetry charges will only be paid if observation ("OBS") charges do not exceed approved average semi-private room and board rate less discount, as submitted to Anthem.

## **TEST OR PROCEDURES PRIOR TO ADMISSION(S) OR OUTPATIENT SERVICES**

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/preoperative testing:

- 254 – Drugs incident to other diagnostic services
- 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological
- 32X – Radiology diagnostic
- 341 – Nuclear medicine, diagnostic
- 35X – CT scan
- 40X – Other imaging services
- 46X – Pulmonary function
- 48X – Cardiology
- 53X – Osteopathic services
- 61X – MRI
- 62X – Medical/surgical supplies, incident to radiology or other services
- 73X – EKG/ECG
- 74X – EEG
- 92X – Other diagnostic services

Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member's admission as an inpatient.

Unless the Provider or Facility Agreement with Anthem specifies a different timeframe, pre-admission/pre-surgical/ pre-operative testing that occurs within seventy-two (72) hours prior to the inpatient admission or outpatient procedure will be included in the DRG Rate, Per Diem Rate, Case Rate or any other fixed Anthem Rate for Covered Services, and will not be paid separately. All Claims billed separately for these services must be accompanied with the appropriate ICD-10 codes.

## TIME CALCULATION

- **Operating Room ("OR")** –Time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Recovery Room** – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room** – Time charges should be calculated from the time the patient leaves the recovery room until discharge
- **Hospital/ Technical Anesthesia Component-** Time should be calculated from the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and in the recovery room is not to be included in the hospital anesthesia time calculation.

## UNDOCUMENTED OR UNSUPPORTED CHARGES

Per Anthem policy, Anthem will not reimburse charges that are not documented on medical records or supported with documentation.

## VIDEO OR DIGITAL EQUIPMENT USED IN OPERATING ROOM

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

## ADDITIONAL REIMBURSEMENT GUIDELINES FOR DISALLOWED CHARGES

For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, **but are not limited to**, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by a specific Agreement. Refer to the contractual fee schedule for payment determination.

**The tables below illustrate examples of non-reimbursable items/services codes:**

## Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0990 – 0999	Personal Care Items <ul style="list-style-type: none"> <li>• Courtesy/Hospitality Room</li> <li>• Patient Convenience Items (0990)</li> <li>• Cafeteria, Guest Tray (0991)</li> <li>• Private Linen Service (0992)</li> <li>• Telephone, Telegraph (0993)</li> <li>• TV, Radio (0994)</li> <li>• Non-patient Room Rentals (0995)</li> <li>• Beauty Shop, Barber (0998)</li> <li>• Other Patient Convenience Items (0999)</li> </ul>
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	<b>Supplies and Equipment</b> <ul style="list-style-type: none"> <li>• Blood Pressure cuffs/Stethoscopes</li> <li>• Thermometers, Temperature Probes, etc.</li> <li>• Pacing Cables/Wires/Probes</li> <li>• Pressure/Pump Transducers</li> <li>• Transducer Kits/Packs</li> <li>• SCD Sleeves/Compression Sleeves/Ted Hose;</li> <li>• Oximeter Sensors/Probes/Covers</li> <li>• Electrodes, Electrode Cables/Wires</li> <li>• Oral swabs/toothettes;</li> <li>• Wipes (baby, cleansing, etc.)</li> <li>• Bedpans/Urinals</li> <li>• Bed Scales/Alarms</li> </ul>

## Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Specialty Beds</li> <li>• Foley/Straight Catheters, Urometers/Leg Bags/Tubing</li> <li>• Specimen traps/containers/kits;</li> <li>• Tourniquets;</li> <li>• Syringes/Needles/Lancets/Butterflies</li> <li>• Isolation carts/supplies;</li> <li>• Dressing Change Trays/Packs/Kits</li> <li>• Dressings/Gauze/Sponges;</li> <li>• Kerlix/Tegaderm/OpSite/Telfa</li> <li>• Skin cleansers/preps;</li> <li>• Cotton Balls; Band-Aids, Tape, Q-Tips</li> <li>• Diapers/Chucks/Pads/Briefs</li> <li>• Irrigation Solutions</li> <li>• ID/Allergy bracelets;</li> <li>• Foley stat lock;</li> <li>• Gloves/Gowns/Drapes/Covers/Blankets;</li> <li>• Ice Packs/Heating Pads/Water Bottles</li> <li>• Kits/Packs (Gowns, Towels and Drapes);</li> <li>• Basins/basin sets;</li> <li>• Positioning Aides/Wedges/Pillows;</li> <li>• Suction Canisters/Tubing/Tips/Catheters/Liners</li> <li>• Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.)</li> <li>• Preps/prep trays;</li> <li>• Masks (including CPAP and Nasal Cannulas/Prongs);</li> <li>• Bonnets/Hats/Hoods;</li> <li>• Smoke Evacuator Tubing;</li> <li>• Restraints/Posey Belts</li> <li>• OR Equipment/Supplies (saws, skin staplers, staples &amp; staple removers, sutures, scalpels, blades etc.)</li> <li>• IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.);</li> </ul>
0220 – 0222, 0229, 0250	<p>Tech Support Charges</p> <ul style="list-style-type: none"> <li>• Pharmacy Administrative Fee (including mixing meds)</li> </ul>

## Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility)</li> <li>Patient transport fees</li> </ul>
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366); IV Infusion additional for therapy: IV Infusion concurrent for therapy (96368); IV Injection (96374, 96379)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	Other Special Charges <ul style="list-style-type: none"> <li>Observations hours may never exceed the charge of a semiprivate room charge</li> <li>Oxygen charges while a patient is on a ventilator</li> <li>Respiratory assessment/vent management charges</li> </ul>
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) <ul style="list-style-type: none"> <li>Medication prep</li> </ul>



## Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Nonspecific descriptions</li> <li>• Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges</li> <li>• IV Solutions 250 cc or less</li> <li>• Miscellaneous Descriptions</li> <li>• Non-FDA Approved Medications</li> </ul>
0256	Experimental Drugs
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	<ul style="list-style-type: none"> <li>• Venipuncture (CPT Code 36415, 36416 or G0001)</li> <li>• Specimen collection</li> <li>• Draw fees</li> <li>• Phlebotomy</li> <li>• Heel stick</li> <li>• Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399)</li> <li>• Thawing/Pooling Fees</li> </ul>
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	<b>Supplies and Equipment</b> <ul style="list-style-type: none"> <li>• Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and/or the room and board</li> <li>• Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery</li> <li>• Instrument Trays and/or Surgical Packs</li> <li>• Drills/Saws (All power equipment used in O.R.)</li> <li>• Drill Bits</li> <li>• Blades</li> <li>• IV pumps and PCA (Patient Controlled Analgesia) pumps</li> <li>• Isolation supplies</li> <li>• Daily Floor Supply Charges</li> <li>• X-ray Aprons/Shields</li> <li>• Blood Pressure Monitor</li> <li>• Beds/Mattress</li> </ul>

## Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Patient Lifts/Slings</li> <li>• Restraints</li> <li>• Transfer Belt</li> <li>• Bair Hugger Machine/Blankets</li> <li>• SCD Pumps</li> <li>• Heal/Elbow Protector</li> <li>• Burrs</li> <li>• Cardiac Monitor</li> <li>• EKG Electrodes</li> <li>• Vent Circuit</li> <li>• Suction Supplies for Vent Patient</li> <li>• Electrocautery Grounding Pad</li> <li>• Bovie Tips/Electrodes</li> <li>• Anesthesia Supplies When Billed with Anesthesia Time Charges</li> <li>• Anesthesia Circuit</li> <li>• Perfusion Supplies When Billed with Perfusionist Time Charge</li> <li>• Case Carts</li> <li>• C-Arm/Fluoroscopic Charge</li> <li>• Wound Vacuum Pump</li> <li>• Bovie/Electro Cautery Unit</li> <li>• Wall Suction</li> <li>• Retractors</li> <li>• Single Instruments</li> <li>• Oximeter Monitor</li> <li>• CPM Machines</li> <li>• Lasers</li> <li>• DaVinci Machine/Robot</li> </ul>
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation) <ul style="list-style-type: none"> <li>• Nursing care</li> <li>• Monitoring</li> <li>• Intervention</li> <li>• Pre- or Post-evaluation and education</li> <li>• IV sedation and local anesthesia</li> <li>• Intubation/Extubation</li> <li>• CPR</li> </ul>

### Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
410	<p>Nursing/Respiratory Functions:</p> <ul style="list-style-type: none"> <li>• Oximetry (94760, 94761, 94762)</li> <li>• Oximetry reading by nurse or respiratory tech</li> <li>• Vent Management</li> <li>• Postural Drainage</li> <li>• Suctioning Procedure</li> <li>• Nursing/Respiratory care performed while patient is on vent</li> </ul>
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges
0940 – 0945	Education/Training
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)

### Member Responsibility

Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0110 – 0119	Private Room*
0990	Patient Convenience Items
0991	Cafeteria, Guest Tray
0992	Private Linen Service
0993	Telephone, Telegraph
0994	TV, Radio

## Facility Responsibility

Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0995	Non-patient Room Rentals
0996	Late Discharge
0998	Beauty Shop, Barber
0999	Other Patient Convenience Items

\* Subject to the Member's Benefit Agreement.

## Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of health care. Anthem adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of Members. Several national organizations such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. Anthem reviews the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to [anthem.com](https://www.anthem.com). Select **Providers** and **Georgia**, if needed then select **Policies, Guidelines and Manuals** from the horizontal menu under Provider Resources. Scroll to **Clinical Practice Guidelines** and select [Download Index](#)

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the clinical practice guidelines.

## Preventive Health Guidelines

Anthem considers prevention an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the

American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. Anthem reviews the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. Anthem encourages physicians to utilize these guidelines to improve the health of Members.

The current guidelines are available online. To access the guidelines, go to [anthem.com](https://www.anthem.com). Select **Providers** and **Georgia**, if needed then select Policies, Guidelines and Manuals from the horizontal menu under Provider Resources. Scroll to **Preventive Health Guidelines** and select [Review the guidelines](#)

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the preventive health guidelines.

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## Medical Policies and Clinical Utilization Management (“UM”) Guidelines

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The Office of Medical Policy & Technology Assessment (“OMPTA”) develops medical policy and clinical UM guidelines (collectively, “Medical Policy”) for Anthem. The principal component of the process is the review for development of Medical Necessity and/or investigational position statements or clinical indications that are objective and based on medical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments, may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

Medical Policies are intended to reflect current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures, Federal and State law, as well as contract language, including definitions and specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

The Medical Policy & Technology Assessment Committee (“MPTAC”) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. Voting Membership may include external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks, internal medical directors and Chairs of MPTAC Subcommittees. Non-voting Members may include internal legal counsel and internal medical directors.

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, is provided in [ADMIN.00001 Medical Policy Formation](#).

## MEDICAL POLICY AND CLINICAL UM GUIDELINES DISTINCTION

Medical Policy and clinical UM guidelines differ in the type of determination being made. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Medical Policy may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care. In addition, Medical Policies are implemented by all Anthem Plans while clinical UM guidelines are adopted and implemented at the local Anthem Plan or line of business discretion.

## ACCESSING MEDICAL POLICIES AND CLINICAL UM GUIDELINES

Anthem Medical Policies are available on [anthem.com](#), which provides transparency for Providers, Facilities, Members and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the Anthem website, but are available upon request.

To locate Medical Policy online, go to [anthem.com](#). Select **Providers**, under **Provider Resources** select **Policies, Guidelines & Manuals**, then select Georgia, if needed. Select “**View Medical Policies & Clinical UM Guidelines**”. Search for policies or select “Full List page” to view. Page link is included below:

- [Medical Policy and Clinical UM Guidelines](#)

To locate Medical Policy and Clinical UM Guidelines and Prior Authorization requirements for BlueCard® out-of-area members, go to [anthem.com](#). Select Providers and then select Georgia, if needed, then choose “**Prior Authorization**” under Claims in the horizontal menu. Scroll down the page to **Helpful Links** and select “**Medical Policy and Prior Authorization for Blue Plans**”. Page link is included below:

- [Medical Policy and Prior Authorization for BLue Plans](#)

## CLINICAL UM GUIDELINES

The clinical UM guidelines published on [anthem.com](#) represent the clinical UM guidelines currently available to all Plans for adoption throughout the organization. Because local practice patterns, Claims systems and benefit designs vary, a local Plan or line of business may choose whether to implement a particular clinical UM guideline. The link below can be used to confirm whether the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by Georgia scroll to the bottom of the Clinical UM Guidelines section and select the link titled [Clinical UM Guidelines](#) “Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Georgia

## OTHER CRITERIA

In addition to Medical Policy and Clinical UM Guidelines Anthem maintains for coverage decisions, Anthem may adopt criteria developed and maintained by other organizations. Where Anthem has developed a policy that addresses a service also described in one of these other sets of criteria, Anthem's policy supersedes. To access this other criteria, go to **anthem.com**. Select **Providers**, under **Provider Resources** select **Policies, Guidelines & Manuals**, then select **Georgia**, if needed, Select **View Medical Policies & Clinical UM Guidelines** and scroll to **Other Criteria** and Select the specific criteria needed.

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# Utilization Management

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## UTILIZATION MANAGEMENT PROGRAM

The Utilization Management ("UM") Program goal is to have Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following UM Program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information required to complete Anthem's UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this section.

Utilization management decisions are based on medical necessity and appropriateness of care and service, and the organization does not specifically reward denials of coverage.

## UM DEFINITIONS

1. **Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to Prospective, Continued Stay, and Retrospective reviews.
2. **Business day:** Monday through Friday, excluding Anthem company holidays.
3. **Continued Stay Review:** (continuation of services). Continued Stay Review means utilization review that is conducted during a Member's ongoing stay in a Facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).
4. **Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the UM determination.
5. **Pre-certification/Pre-authorization Requirement:** List of services that require Pre-service Review by UM prior to service delivery. For UM team to perform Pre-service Review, the Provider submits the pertinent information as soon as possible to UM prior to service delivery.

6. **Pre-Service (Prospective) Review:** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.
7. **Post Service (Retrospective) Review:** means a utilization review that is conducted after the health care service (or supply) has been provided to the Member.
8. **Discharge Planning:** includes coordination of medical services and supplies, medical personnel and family to facilitate the Member's timely discharge to a more appropriate level of care following an inpatient admission.
9. **Urgent Care Review: means** request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:
  - a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
  - b. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
  - c. In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

## PROGRAM OVERVIEW

Utilization Management (UM) may be required for Pre-certification/Pre-authorization, Pre-service (Prospective) Review, Continued Stay Review, or Post-service (Retrospective) Review. UM may be conducted via multiple communication paths.

The determination that services are medically necessary is based on the information provided, and is not a guarantee that benefits will be paid. Payments are based on the Member's coverage at the time of service. These terms typically include certain exclusions, limitations and other conditions. Benefit payment could be limited, for example, when:

- The information submitted with the Claim, or on the medical record, differs from that given for the pre-Claim UM review.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.

Inpatient medical admissions require UM review. UM for inpatient medical services may include but is not limited to: acute hospitalizations, units described as "sub-acute," "step-down" and "skilled nursing Facility;" designated skilled nursing beds/units; comprehensive outpatient rehabilitation facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation facilities or transitional living centers. These services are subject to admission review for determination of Medical Necessity and appropriateness, site of service and level of care.

Non-inpatient medical services may require Pre-Service Review.



The list of Pre-certification/Pre-authorization Requirements can be accessed online. Go to **anthem.com**, and select **Providers**. Under the **Claims** heading, select [Prior Authorization](#). Select **Georgia**, if needed. Select the appropriate link depending on the type of Member.

## PRE-SERVICE REVIEW & CONTINUED STAY REVIEW

- A. Provider or Facility shall ensure both requirements (1) and (2) are met: (1) that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are submitted for review and have a decision rendered before the service occurs. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section. (2) For non-emergency admissions, Provider or Facility shall also provide confirmation to Anthem UM of the necessary demographic information and primary diagnosis within twenty-four (24) hours or next Business Day following the Member's admission.
- B. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within forty-eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section.
- C. Provider or Facility shall verify that the Member's primary care physician has provided a referral as required by certain Health Benefit Plans.
- D. Provider or Facility shall comply with all requests for medical information required to complete Anthem's UM review up to and including discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.
- E. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting the appropriate phone number on the back of the Member's ID card.
- F. When the review is completed, Anthem will provide electronic or written Notification for all Adverse Determinations to the Member and attending practitioner or treating practitioner, as applicable.
- G. UM Review Timeframes follow State, Federal and accreditation requirements as may be applicable to the review.

## MEDICAL POLICIES AND CLINICAL UM GUIDELINES

Refer to the Medical Policies and Clinical Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

## **ON-SITE REVIEW/VIRTUAL REVIEW**

If Anthem maintains an on-site or virtual review program with Facility for an Initial Request/Continued Stay Review, the Facility agrees to cooperate with Anthem and provide Anthem with access to Member's medical and health records.

Certain services such as Transplant may be excluded from On-Site or Virtual Review program

## **OBSERVATION BED POLICY**

Refer to the "Observation Services Policy" located in the Reimbursement Policies section of Anthem.com.

## **RETROSPECTIVE UTILIZATION MANAGEMENT**

Medical records and pertinent information regarding the Member's care may be reviewed to make a Claim determination.

## **FAILURE TO COMPLY WITH UTILIZATION MANAGEMENT PROGRAM**

Provider and Facility acknowledge that Anthem may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under the Agreement or for Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts. Penalties include but are not limited to the following:

If non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are not submitted for review and a decision rendered before the service occurs payment will be subject to a 100% penalty. Providers and Facilities can only appeal the 100% penalty in order to present evidence of extenuating circumstances.

Payment for emergency inpatient admissions will be subject to a 100% penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities can only appeal the 100% penalty in order to present evidence of extenuating circumstances. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day.

## **UTILIZATION STATISTICS INFORMATION**

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:

- Member name
- Member identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- HEDIS Measures or any other pertinent information Anthem deems necessary

This information will be provided by Facility or Provider at no charge to Anthem.

## **ELECTRONIC DATA EXCHANGE**

Facility will support Anthem by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other

relevant clinical data. For additional information go to the Admission, Discharge and Transfer Messaging Data section of this manual which can be found under Legal and Administrative Requirements.

## **SUBMIT AUTHORIZATION REQUESTS DIGITALLY**

Using the Availity multi-payer Authorization application for submitting prior authorizations offers a streamlined and efficient by Anthem plans. Providers can also use the Availity Authorization application to check authorization status, regardless of how the authorization was submitted. For additional information go to the Availity Portal section of this manual which can be found under Anthem Digital Tools.

Transplant Pre-certification/Pre-authorization requests should be submitted via telephone, fax or secured e-mail notification.

## **PEER TO PEER REVIEW PROCESS**

Upon request from a treating practitioner, who is a licensed or certified professional providing medical care or behavioral healthcare services and directly involved in the Member's care/treatment plan, Anthem provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The treating practitioner may offer additional information and/or further discuss his/her cases with a peer clinical reviewer. In compliance with accreditation standards, a practitioner or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

## **QUALITY OF CARE INCIDENT**

Providers and Facilities will notify Anthem in the event there is a quality of care incident that involves a Member.

## **AUDITS/RECORDS REQUESTS**

At anytime Anthem may request on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

## **CASE MANAGEMENT**

Case Management assists Members to optimize the use of their benefits and available community resources to gain access to quality health care in all settings.

The Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Case Management programs are confidential and voluntary and are made available at no extra cost. These programs are provided by, or on behalf of and at the request of, health plan case management staff. These Case Management programs are separate from any Covered Services. If the Member meets program criteria and agrees to take part, we will help the

Member meet identified health care needs. This is reached through contact and team work with the Member and/or the Member's chosen authorized representative, treating Physician(s), and other Providers.

In addition, assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.

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## AIM Specialty Health® (AIM)

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AIM Specialty Health provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, AIM promotes optimal care through use of evidence-based clinical guidelines and real-time decision support for both Providers and their patients. The AIM platform delivers significant cost-of-care savings across an expanding set of clinical domains, including cancer care quality, cardiology, genetic testing, musculoskeletal care, oncology, radiology, rehabilitation, sleep medicine and surgical.

Visit AIM's program microsite [here](#) to find program information, resources, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to AIM **ProviderPortal<sub>SM</sub>**

### SUBMIT PRE-CERTIFICATION/PRE-AUTHORIZATION REQUESTS TO AIM

Ordering and servicing Providers may submit Pre-certification/Pre-authorization requests to AIM in one of the following ways:

- Access AIM **ProviderPortal<sub>SM</sub>** directly at [providerportal.com](https://providerportal.com). Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at [availity.com](https://availity.com)
- Call the AIM Contact Center toll-free number: 866-714-1103, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

### OPTINET® REGISTRATION

The [OptiNet](#) Registration is an important tool that assists ordering Providers in real-time decision support information to enable ordering Providers to choose high quality, low cost **imaging** Providers for their patients. Servicing Providers need to complete the [OptiNet](#) Registration online.

To access the [OptiNet](#) Registration:

- Access AIM **ProviderPortal** directly at [providerportal.com](https://providerportal.com) or [availity.com](https://availity.com).
- Once logged into AIM, from the **My Homepage** screen, choose **Access Your [OptiNet](#) Registration**.
- Select the **Registration Type**, and choose the **Access Your [OptiNet](#) Registration** button.

- Complete requested information.

The registration does not need to be completed in one sitting. Data can be saved as the Provider or Facility proceeds through the registration. Once the registration has been submitted, a score card will be produced. The score for the Facility will be presented to the ordering Provider when the particular Facility is selected as a place of service which drives Ordering Provider Decision Support.

For technical questions, contact AIM **ProviderPortal** Web Support at **800-252-2021**. For any other questions, contact an Anthem **Provider Experience Representative**.

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# Quality Improvement Program

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## QUALITY IMPROVEMENT PROGRAM OVERVIEW

Anthem believes health care is local and Anthem has the strong local presence required to understand and meet Member needs. Anthem is well positioned to deliver what Members want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Anthem provides access to care according to the benefits for covered health services and does not provide care. Anthem's local presence and broad expertise create opportunities for collaborative programs that reward Providers and Facilities for clinical quality and excellence. Providers and Facilities are expected to cooperate with quality activities. Anthem's commitment to health improvement and care management provides added value to Members and Providers – helping improve both health and health care costs. Anthem takes a leadership role to improve the health of communities and is helping to address some of health care's pressing issues. The Quality Improvement ("QI") Program Description defines the quality infrastructure that supports Anthem's QI strategies.

- The QI Program Description establishes QI Program governance, scope, goals, objectives, structure, and responsibilities encompassing the quality of medical and behavioral health care and services provided to Members.
- The development of the QI Work Plan is a dynamic process with updates throughout the year to reflect ongoing progress made on quality activities. The QI Work Plan includes measurable objectives for the year to determine how well the organization is performing, including the approach to improving medical and behavioral health care: quality of clinical care, safety of clinical care, quality of service and Members' experience.
- The QI Evaluation assesses outcomes of Anthem's medical and behavioral health care programs, processes, and activities toward established goals and objectives.

### Goals and Objectives

The following QI program goals and objectives support Anthem's vision and values, promote continuous improvement in quality care, patient safety for Members and quality of service to Members, Providers and Facilities:

- To develop and maintain a well-integrated system to identify, measure, assess, and improve clinical and service quality outcomes through standardized and collaborative activities.

- To evaluate performance and take action and respond to the needs of internal/external customers, including compliance with policies, procedures and regulatory and accreditation requirements.
- To promote processes that help reduce medical errors and improve patient safety for Members by implementing Member and Provider initiatives.
- To identify and promote educational opportunities for Members, medical and behavioral health Providers.
- Address the cultural and linguistic needs of eligible Members to promote improved health and health care outcomes for diverse Members.
- To help maximize health status, improve health outcomes and reduce health care costs of Members through effective Case Management (“CM”), which includes Behavioral Health (“BH”) and Disease Management (“DM”) programs addressing complex care needs and Population Health Management (“PHM”) which includes CM, BH and DM.

As part of the QI Program, initiatives in these major areas include, but are not limited to:

### Quality and Safety of Clinical Care

- **Chronic Disease and Prevention:** Anthem focuses on Member and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and Chronic Obstructive Pulmonary Disease (“COPD”) and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set)<sup>1</sup>.
- **Behavioral Health Case Management (BH CM):** The program as part of population health management focuses on connecting Members with the most appropriate level of care and timely application of evidence-based interventions necessary for the successful and cost-effective management of the BH condition including psychiatric and substance use disorder (SUD). The program works with individuals and their families to understand the options available for BH treatment; advocates for coordination of care, both medical and BH; educates on symptoms and condition management to prevent further inpatient hospitalization stays; identifies and addresses barriers to treatment compliance; offers resources and support improve health outcomes for a better quality of life.
- **Community Health:** Anthem has committed resources and worked with key entities to co-create community-based health initiatives to address public health concerns and societal problems including behavioral health/substance use, cancer, maternal and child health and health equity.
- **Disease Management:** The ConditionCare program is designed to help maximize health status, improve health outcomes, and reduce health care costs for Members diagnosed with Asthma (pediatric and adult), Diabetes (type 1 and type 2, pediatric and adult), Coronary Artery Disease (“CAD”), Heart Failure (“HF”) and COPD. The DM program was created and developed based on nationally accepted evidence-based clinical practice guidelines (“CPGs”). These guidelines are reviewed at least every two years, and program interventions and protocols are updated accordingly.
- **Health and Wellness:** Programs offer a seamless integration of preventive care, wellness, care management coordination services and online and mobile tools. The programs are clinically driven and designed to help Members better manage individual health and make more informed health care decisions and receive the best value for their



health care benefits. Programs include: MyHealth Coach (“MHC”), MyHealth Advantage (“MHA”), Healthwise® Knowledge Base (“HWKB”).

### **Service Quality**

Anthem periodically surveys its Members, monitors the quality of care and service of network Providers and strives to provide excellent service to Members, Providers and Facilities. Anthem actively analyzes business processes, trends, identifies and takes action on opportunities to improve the Member, Provider and Facility experience, recommending appropriate activities to address root causes.

### **Patient Safety for Members**

Patient safety activities are designed to promote safe practices by identifying opportunities for improvement and refining processes throughout the care delivery system. Anthem fosters a supportive environment to assist Medical and Behavioral Health Providers in improving safety within individual practices and across the health care continuum.

To raise awareness of patient safety, Member education is provided regarding medication safety compliance including taking medications as prescribed and potential harmful interactions. Members additionally receive education on chronic medical conditions and are encouraged to become actively involved in their own care by developing a self-management action plan.<sup>1</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## **MEMBER RIGHTS AND RESPONSIBILITIES**

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care benefit plans. One of the first steps is for Members, Providers and Facilities to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members’ Rights and Responsibilities statement which can be accessed by going to **anthem.com**. Select the **For Provider** link at the top of the landing page. Select **Policies, Guidelines and Manuals** (under the Provider Resources column), then **Change/Select a State** at the top right, if needed. Scroll down and select the **Read about Member Rights** link under the **More Resources/Member Rights and Responsibilities** section, then choose the **what are my rights as a Member** FAQ question—Members or Providers who do not have access to the website can request copies by contacting Anthem or by calling the number on the back of the Member ID card.

## **CONTINUITY AND COORDINATION OF CARE**

Anthem encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other health care professionals who are involved in providing care to Anthem Members. Discuss the importance of this communication with each Member and make every reasonable attempt to elicit permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between Covered Entities for the purposes of Treatment, Payment and Health Care Operations.

The Anthem QI Program is an ongoing and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health care services offered by Providers.

## CONTINUITY OF CARE/TRANSITION OF CARE PROGRAM

This program is for Members when their Provider or Facility terminates from the network and new Members (meeting certain criteria) who have been participating in active treatment with a Provider not within Anthem's network.

Anthem makes reasonable efforts to notify Members affected by the termination of a Provider or Facility according to contractual, regulatory and accreditation requirements and prior to the effective termination date. Anthem also helps them select a new Provider or Facility.

Anthem will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Members, or their covered dependents with qualifying conditions, need assistance in transitioning to in-network Providers or Facilities. The goal of this process is to minimize service interruption and to assist in coordinating a safe transition of care. Completion of Covered Services may be allowed at an in-network benefit and reimbursement level with an out-of-network Provider for a period of time, according to contractual, regulatory and accreditation requirements, when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider or Facility.

Completion of Covered Services by a Provider or Facility whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

In addition to the above, due to the requirements of the Federal Consolidation Appropriations Act (CAA), effective January 1, 2022, there are federal continuity of care obligations resulting from (i) the termination of Providers or Facilities from Anthem's network and (ii) the termination of a group health plan from Anthem that results in a loss of benefits provided under such group health plan with respect to Provider or Facility.

Members may contact Customer Care to get information on Continuity of Care/Transition of Care.

## QUALITY-IN-SIGHTS®: HOSPITAL INCENTIVE PROGRAM (Q-HIP SM)

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is Anthem's performance-based reimbursement program for hospitals. The mission of Q-HIP is to help improve patient outcomes in a hospital setting and promote health care value by financially rewarding hospitals for practicing evidence-based medicine and implementing best practices. Q-HIP strives to promote improvement in health care quality and to raise the bar by moving the bell shaped "quality curve" to the right towards high performance.

Q-HIP measures are credible, valid, and reliable because they are based on measures developed and endorsed by national organizations which may include:

- American College of Cardiology (ACC)
- Center for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)
- The Joint Commission (JC)
- The Society of Thoracic Surgeons (STS)

In order to align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the Centers for Medicare and Medicaid Services'



Hospital Compare database. The measures can be tracked and compared within and among hospital[s] for all patient data – regardless of health plan carrier.

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel on Value Solutions (“NAPVS”) was established in 2009 to provide input during the scorecard development process. The NAPVS is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

Participating hospitals are required to provide Anthem with data on measures outlined in the Q-HIP Manual. Q-HIP measures are based on commonly accepted indicators of hospitals’ quality of care. Participating hospitals will receive a copy of their individual scorecard which shows their performance on the Q-HIP measures.

## **QUALITY-IN-SIGHTS®: PRIMARY CARE INCENTIVE PROGRAM**

The Quality-In-Sights Primary Care Incentive Program rewards physician practices for meeting or exceeding established targets related to quality, patient safety, applicable external recognition programs, and adoption of technology.

Specialties included in the Quality-In-Sights Primary Care Incentive Program

The program is open to Providers who specialize in Family Medicine, General Practice, Internal Medicine and/or Pediatrics as their designated primary specialty, who meet eligibility requirements and who provide primary care services to Members of Anthem and Anthem enrolled in a HMO, Point of Service or PPO Health Benefit Plan product.

## **PERFORMANCE DATA**

Provider/Facility Performance Data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

## **OVERVIEW OF HEDIS®**

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem’s HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance

with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes 91\* measures across 6\* domains: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilization, Health Plan Descriptive Information, and Measures Reported using Electronic Clinical Data Systems. Record requests to Provider offices is a year round process. Anthem requests the records be returned within the specified time frame to allow time to abstract the records and request additional information if needed from other Providers. Health plans use HEDIS data to encourage their contracted Providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs

For more information on HEDIS visit [Anthem.com](https://www.anthem.com), Select **Providers**, Select **Forms and Guides** (under the Provider Resources column), if needed **pick the state** using the **Change State** link at the top right. Scroll down and select **Forms and Guides**, then scroll down and select **HEDIS** in the Category drop down.

\*Subject to change

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## OVERVIEW OF CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Anthem's Members about their experiences with Anthem's Health Plans in the past year. This includes the Member's access to medical care and the quality of the services provided by Anthem's network of Providers. Anthem analyzes this feedback to identify issues causing Members dissatisfaction and works to develop effective interventions to address them. Anthem takes this survey feedback very seriously.

Health Plans report survey results to National Committee for Quality Assurance ("NCQA"), which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via the Provider newsletter, so they have an opportunity to learn how Anthem Members feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one. Provider newsletters can be found online at [anthem.com/provider/news](https://www.anthem.com/provider/news)

® **CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).**

## MEDICAL RECORD STANDARDS

Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care. Anthem has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

For more information on Medical Record Standards visit [anthem.com](https://www.anthem.com), select **Providers**, select **Forms and Guide** (under the Provider Resources column), if needed select **Georgia** using the **Change State** link at the top right, then scroll down and select **Medical Records** in the Category drop down.

## MEMBER SAFETY

### Leapfrog Group

The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer Members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.

The Leapfrog Group aims to:

- Reduce preventable medical mistakes and improve the quality and affordability of health care.
- Encourage health Providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices.
- Reward doctors and hospitals for improving the quality, safety and affordability of health care.
- Help consumers reap the benefits of making smart health care decisions.
- Network hospitals are encouraged to join the Leapfrog Group and implement policies to reduce medical errors and improve Member safety. In 2006, there was a 30% increase in HMO/POS participation/response to survey and a 20% increase in the PPO participation/response to survey. There was a significant increase in the 'Evidenced Based Hospital Referral' (EHR) leap and 100% of facilities attained the "Fully implemented" rating for "National Quality Forum-Endorsed Safe Practices" (NQF-S) leap.

Hospitals that have not completed the survey, can do so by logging on to the Leapfrog Group Web site at [www.leapfroggroup.org](http://www.leapfroggroup.org).

## PARTNERSHIP FOR HEALTH AND ACCOUNTABILITY

Georgia's Partnership for Health and Accountability ("PHA"), initiated with the funding of Georgia Hospital Association, an Association of Hospitals and Health Systems, recognizes Member safety as its top priority and describes the elements that support a culture of safety in healthcare organizations. Among these are a pervasive commitment to Member safety, open communication, a blame-free environment, and the importance of safety design in preventing future errors. Acknowledging that success in creating a culture of safety requires the commitment of both organizational leadership and frontline health care workers; PHA stresses the critical role of physicians and employees in the process.

PHA brings together the healthcare field with agencies and individuals to ensure quality and safety in healthy communities. PHA assists in strengthening collaboration between Providers, community Members, and other stakeholders by providing education and data-driven tools to facilitate improvement.

Anthem serves on the PHA Advisory Council, whose role is to provide advice, develop consensus and make recommendations on major issues and communicate that information to their constituent groups and others that affect health policy throughout the state.

# Culturally & Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for Providers and Facilities to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Anthem wants to help work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff Members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and Providers. A person's cultural affiliations can influence:

- Where and how care is accessed; how symptoms are described,
- Expectations of care and treatment options, and
- Adherence to care recommendations.

Providers and Facilities also bring their own cultural orientations, including the culture of medicine. Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family Members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Anthem ensures Providers and Facilities have access to resources to help support delivery of culturally and linguistically appropriate services. Anthem encourages Providers and Facilities to access and utilize [MyDiversePatients.com](https://www.mypatient.com)

**MyDiversePatients.com:** The My Diverse Patient website offers resources, information, and techniques, to help Providers and Facilities provide the individualized care every Member deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **Creating an LGBT-Friendly Practice:** Helps Providers understand the fears and anxieties LGBT patients often feel about seeking medical care, learn key health concerns of LGBT patients, & develop strategies for providing effective health care to LGBT patients.
- **Improving the Patient Experience:** Helps Providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps Providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps Providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps Providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both Providers' patients and practices, and how to do so.

**Anthem appreciates the shared commitment by Providers and Facilities to ensure Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.**

## Centers of Medical Excellence

Anthem currently offers access to Centers of Medical Excellence ("CME") programs in solid organ and blood/marrow transplants, bariatric surgery, cancer care, cardiac care, maternity, spine surgery, knee/hip replacement surgery, fertility care, cellular immunotherapy CAR-T, gene therapy (for ocular disorders), and substance use treatment and recovery. As much of the demand for CME programs has come from National Accounts, most of Anthem's programs are developed in partnership with the Blue Cross and Blue Shield Association ("BCBSA") and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME Providers as Blue Distinction Centers for Specialty Care™ ("BDC"). Using objective information and input from the medical community, the BCBSA has designated hospitals, ambulatory surgery centers (ASCs), physicians, and/or clinics as Blue Distinction Centers that are proven to outperform their peers in the areas of– quality, safety and, in the case of Blue Distinction Centers+ ("BDC+"), cost efficiency.

For transplants, cellular immunotherapy CAR-T and ventricular assist devices ("VAD"), Members also have access to the Anthem Centers of Medical Excellence Transplant, Cellular Immunotherapy and VAD Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ, bone marrow transplantation, and cardiac surgery representing centers across the country. Each Center must meet Anthem's CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility's structures, processes, and outcomes of care. Current transplant designations include the following transplants: adult and pediatric

autologous/allogeneic bone marrow/stem cell, adult and pediatric heart, adult and pediatric lung, adult combination heart/lung, adult and pediatric liver, adult and pediatric kidney, adult simultaneous kidney/pancreas and adult pancreas.

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the Facility delivers specialty care. More information on the programs can be accessed online at [anthem.com](https://www.anthem.com). To view the BDC and Anthem CME program information [Click Here](#)

## TRANSPLANT

- Blue Distinction Centers for Transplant™ (“BDCT”) launched in 2006.
- Nearly 107,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 140 transplant centers in 2019. There were nearly 40,000 organ transplants in 2020.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations\*\*, including the Center for International Blood and Marrow Transplant Research (“CIBMTR”), the Scientific Registry of Transplant Recipients (“SRTR”), and the Foundation for the Accreditation of Cellular Therapy (“FACT”), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, Members have access to over 400 transplant specific programs for heart, lung, combined heart/lung, liver, liver kidney, pancreas, kidney, combined kidney/pancreas, and bone marrow/stem cell transplant.

## CARDIAC CARE

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 30.3 million, and the percent of adults with diagnosed heart disease is 12.1%. Heart Disease is the #1 Cause of death in the United States.
- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 21



percent more cost-efficient than non-designated hospitals for those same cardiac procedures.

- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery and cardiac valve surgery).

## **BARIATRIC SURGERY**

- Blue Distinction Centers for Bariatric Surgery® launched in 2008
- According to the National Center for Health Statistics report released in October 2017 Prevalence of Obesity among Adults and Youth has grown to more than one-third (42.4%) of U.S. adults which have been diagnosed with obesity, and 40% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.
- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each Facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (“ASMBS”) and the American College of Surgeons (“ACS”), and is subject to periodic re-evaluation as criteria continue to evolve
- The 2020 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (“MBSAQIP”) accreditation levels, which focus on site of service. With this design change, each Facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (“ASC”).

## **CANCER CARE**

- Blue Distinction Centers for Cancer Care is a new national designation program that recognizes physicians, physician practices, cancer centers, and hospitals for their efforts in coordinating all types of cancer care. This program incorporates patient-centered and data-driven practices, to coordinate care better and to improve quality of care and safety, as well as affordability. Providers in this Program are paid under a Provider Agreement with their local BCBS Plan that has value-based reimbursement, rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.
- Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

## **SPINE SURGERY**

- Blue Distinction Centers for Spine Surgery® launched in November 2009.
- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available for Providers to work with Members, to

guide them toward the most appropriate recommendation for their situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.

- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- In 2019, Blue Distinction Specialty Care Program for Spine Surgery expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an onsite ICU.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
- To date, Anthem has designated hospitals in the majority of states across the U.S.

## **KNEE AND HIP REPLACEMENT**

- Blue Distinction Centers for Knee and Hip Replacement™ launched in November 2009.
- In 2019, Blue Distinction Specialty Care Program for Knee and Hip Replacement expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an onsite ICU.
- Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

## **MATERNITY CARE**

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise, a commitment to quality care, and safety during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01), Cesarean Section (PC-02) and selected patient experience measures at the Facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”). As well as additional measures to support safe practices in childbirth.

## **SUBSTANCE USE TREATMENT AND RECOVERY**

- Blue Distinction Centers for Substance Use Treatment and Recovery launched in January of 2020 to address the treatment of substance use disorders, including opioid use disorder.
- The program aims to improve patient outcomes and cost by addressing the fragmented delivery of substance use disorder treatment. Designations are awarded based on



quality criteria that support delivery of timely, coordinated, multidisciplinary, evidence-based care, with a focus on quality improvement and patient-centered care.

## **VENTRICULAR ASSIST DEVICES**

- Anthem's Centers of Medical Excellence Ventricular Assist Device (VAD) launched in 2017. VADs are implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure.
- According to the Centers for Disease Control and Prevention Heart failure reports that about 6.2 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

## **CELLULAR IMMUNOTHERAPY (Chimeric Antigen Receptor Therapy -"CAR-T")**

- The U.S. Food & Drug Administration (FDA) continues to approve new cellular immunotherapy products called Chimeric Antigen Receptor T-cell (CAR-T), which are genetically modified autologous T cell immunotherapies that provide new treatment options for cancer patients. This treatment involves genetic re-engineering of a patient's white blood cells.
- There are five Chimeric Antigen Receptor T cell therapies (CAR-T) products listed below, approved by the FDA.: The list continues to grow as new products are approved:
  1. Yescarta® (axicabtagene ciloleucel) for treatment in Adult Patients
  2. Kymriah® (tisagenlecleucel) for treatment in Pediatric and Adult Patients
  3. Tecartus™ (brexucabtagene autoleucel) for treatment in Adult Patients
  4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
  5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.

- Anthem is developing a Centers of Medical Excellence Network. These programs will be reviewed by the Bone Marrow National Transplant Quality Review Committee. .  
Currently there are four contracted CAR-T CME Providers. Until a Provider or Facility is contracted, each referral will require a Letter of Agreement.
- The Blue Cross Blue Shield Association will also have a designation, but not a contract requirement for CAR-T Providers in 2020. Providers must be certified by a product manufacturer certification program to deliver CAR-T therapy.

## Audit and Review

### ANTHEM AUDIT AND PREPAYMENT REVIEW POLICY

All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Anthem and Provider or Facility, unless otherwise defined below for this section. This section does not apply to audits or reviews performed by the Special Investigations Unit, ("SIU"). For information on SIU processes, refer to the Fraud Waste and Abuse section located in this Manual.

There may be times when Anthem conducts Claim reviews or audits to confirm that charges for covered healthcare services are accurately reported and reimbursed in compliance with the Provider or Facility Agreement and Anthem's policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records and/or itemized bill. Anthem may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies.

This policy documents Anthem's guidelines for Claims requiring additional documentation and the Provider's or Facility's compliance for the provision of requested documentation.

#### Definition:

The following definitions shall apply to this Audit and Review section only:

- **Agreement** means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- **Appeal** means a written request with supporting documentation to Anthem from a Provider or Facility to reconsider a payment determination.
- **Appeal Response** means Anthem's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.

- **Audit** means post payment evaluation of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining appropriate reimbursement under the terms of the Agreement.
- **Business Associate or Designee** means a third party designated by Anthem to perform an Audit or any related function on behalf of Anthem.
- **Notice of Overpayment** means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem. The Notice of Overpayment shall contain administrative data relating to the amount of overpayment. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Notice of Overpayment shall be sent to Provider or Facility.
- **Provider Manual** means the proprietary Anthem document available to the Provider and Facility, which outlines Reimbursement Requirements and Policies.
- **Recoupment** means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. In accordance with applicable laws, regulations and unless an Agreement expressly states otherwise, a Recoupment may be performed against a separate Anthem payment unrelated to the service or subject made to the Provider or Facility.
- **Review** means the Claim and supporting documentation will be evaluated prior to payment.
- **Supporting Documentation** means the written material contained in a Member's medical records or other Provider or Facility documentation, Claim details, prior authorization clinical information, and supply invoices supporting the Provider's or Facility's Claim.

#### **Documents Reviewed During an Audit or Review:**

The following is a description of the documents that may be reviewed by Anthem or its designee along with a short explanation of the importance of each of the documents in the Audit and Review processes. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

##### **A. Confirm that Health Services were delivered by the Provider or Facility**

Auditors/Reviewers will verify that Provider or Facility's Claim is corroborated by Supporting Documentation reflecting the Health Services delivered and billed by the Provider or Facility. The Provider or Facility must review, approve and document all such policies and procedures by any applicable accreditation bodies.

##### **B. Confirm charges were accurately reported on the Claim in compliance with Anthem's Policies as well as general industry standard guidelines and regulations.**

Auditors/Reviewers may review Supporting Documentation including the Member's health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

Auditors/Reviewers may review the Claim Itemized Billing for a break down of the services billed and supply invoices for pricing determinations.

Auditors/Reviewers may reference the Anthem Reimbursement Policies available on [anthem.com](http://anthem.com).

## Policy

Upon request from Anthem or its designee, Providers and Facilities are required to submit additional documentation for Claims identified for pre-payment review or post payment audit.

Anthem or its designee will use the following guidelines for records requests for Claims identified for pre-payment review or post payment audit. A request may be made via a paper or an electronic format.

- A Provider's or Facility's physical or electronic address may be confirmed prior to an original letter of request for supporting documentation is sent.
- When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
- When a response is not received within 15 days of date of the second request, a final request letter will be sent.
- When a response is not received within 15 days of the date of the final request (60 days total):
  - Anthem or its designee will initiate Claim denial for Claims identified as pre-payment review or post payment audit as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment denials.

Or

- Anthem or its designee will initiate recoupments for Claims identified as post payment audit as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such recoupments.

Anthem or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for Claims identified for pre-payment review or post payment audit.

## Procedure:

- Review of Documents: Anthem or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.
- Desk or Off-site Audits: Anthem or its designee may conduct Audits from its offices and/or offsite locations. Facility or Provider will comply with timeline and specific requested documentation listed in Anthem's request for additional documentation.
- Completion of Desk or Off-site Audit: Upon completion of the Audit where an overpayment is identified, Anthem will generate a Notice of Overpayment. The Notice of Overpayment will identify the Claim overpayment and include an explanation remark for the overpayment. If the Provider or Facility agrees with the Notice of Overpayment, then the Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the form of a refund.

Should the Provider or Facility disagree with the Notice of Overpayment, then the Provider or Facility may Appeal the Notice of Overpayment. If the Provider or Facility does not submit an Appeal against the Notice of Overpayment and does not reimburse Anthem within the thirty (30) calendar days, then Anthem will initiate recoupment as applicable and determined per Provider or Facility Agreement and state guidelines.

- Provider or Facility Appeals: See Audit Appeal Policy.
- On-site Audits: Anthem or its designee may but is not required to, conduct Audits on-site at the Provider's or Facility's location. If Anthem or its designee conducts an Audit at a Provider's or Facility's location, Provider or Facility will make available suitable workspace for Anthem's or its designee's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization.

When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available.

All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

- Completion of Audit (On-site Audit only): Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit.

During the exit interview, Anthem or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation.

If the Provider or Facility agrees with the Audit findings and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging Agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

- Provider or Facility Appeals: See Audit Appeal Policy.

- No Appeal (On-site audit only): If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.
- Scheduling of Audit (Hospital Bill Audits Only): After review of the documents submitted, if Anthem or its designee determines an Audit is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
- Rescheduling of Audit: Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's or Facility's rescheduling. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.
- Under-billed and Late-billed Claims: During an audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit.

## AUDIT APPEAL POLICY

### Purpose:

To establish a timeline for responding to Provider or Facility Appeals of Audits. This section does not apply to appeals or reconsideration of Claims denied on pre-payment review. If Provider or Facility does not agree with the Claim determination for Claims denied on a pre-payment review basis, follow the directions in the Claims Payment Dispute section of this Provider Manual.

### Procedure:

- Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the findings in the Notice of Overpayment. An Appeal of the Notice of Overpayment must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Notice of Overpayment unless applicable law expressly indicates otherwise. The Appeal should address the findings from the Notice of Overpayment that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. If the Provider or Facility does not timely appeal, retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or applicable law.
- Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem's or its designee's response shall address each matter



contained in the Provider's or Facility's Appeal. If appropriate, Anthem's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Anthem's or its designee's response shall be sent via email, mail or portal to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation.

- The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.
- Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. Anthem's or its designee's final Appeal Response shall be sent via email, mail or portal to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation.

If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response.

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## Fraud, Waste and Abuse Detection

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Anthem is committed to protecting the integrity of Anthem's health care programs and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it - or any other person.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When health care Providers or suppliers do not follow good medical practices resulting in excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the

Member listed on the card. It is the first line of defense against possible fraud. Learn more at [www.fightthehealthcarefraud.com](http://www.fightthehealthcarefraud.com)

## REPORTING FRAUD, WASTE AND ABUSE

If someone suspects a Member or Provider has committed fraud, waste or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

Report concerns by:

- Visit [anthem.com](http://anthem.com), scroll to the bottom footer and click on “Healthcare Fraud Prevention” to be directed to the [fightthehealthcarefraud](http://fightthehealthcarefraud.com) education site; at the top of the page click “Report it” and complete the “[Report Waste, Fraud and Abuse](#)” form
- Calling Provider Solutions

Any incident of fraud, waste or abuse may be reported to Anthem anonymously; however, Anthem’s ability to investigate an anonymously reported matter may be limited if Anthem doesn’t have enough information. Anthem encourages Providers and Facilities to give as much information as possible. Anthem appreciates referrals for suspected fraud, but be advised that Anthem do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the Member’s ID (Identification) card
- Obtaining controlled substances from multiple Providers
- Relocating to out-of-service Plan area
- Using someone else’s ID card

When reporting concerns involving a Member include:

- The Member’s name
- The Member’s date of birth, Member ID or case number if available
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

Examples of Provider/Facility Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a Provider (a doctor, dentist, counselor, medical supply company, etc.) include:



- Name, address and phone number of Provider
- Name and address of the Facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and Facility, if available
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To learn more about health care fraud and how to aid in the prevention on it, visit [www.fighthealthcarefraud.com](http://www.fighthealthcarefraud.com).

## INVESTIGATION PROCESS

The Special Investigations Unit (“SIU”) investigates suspected incidents of FWA for all types of services. Anthem may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education:* Anthem sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- *Medical record review:* Anthem reviews medical records to investigate allegations or validate the appropriateness of Claims submissions.
- *Edits:* A certified professional coder or investigator evaluates Claims and places payment or system edits in Anthem’s Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- *Recoveries:* Anthem recovers overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from the network, or legal action.

If working with the SIU, all communication (checks, correspondence) should be sent to:

Anthem Blue Cross and Blue Shield  
Special Investigations Unit  
740 W Peachtree Street NW  
Atlanta, Georgia 30308  
Attn: investigator name, #case number

**Paper** medical records and Claims are a different address, which is supplied in correspondence from the SIU. For questions, contact the investigator. An opportunity to submit Claims and medical records electronically is an option registering for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

## PREPAYMENT REVIEW

One method Anthem uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Anthem’s attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Anthem's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's actions may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Anthem can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Anthem in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Anthem may review coding, documentation, and other billing issues. In addition, Anthem may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members.

The Provider or Facility will remain subject to the prepayment review process until Anthem is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from the network.

Finally, Providers and Facilities are prohibited from billing a Member for services Anthem has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

## **ACTING ON INVESTIGATIVE FINDINGS**

In addition to the previously mentioned actions, Anthem may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies

## **RECOUPMENT/OFFSET/ADJUSTMENT FOR OVERPAYMENTS**

Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider or Facility ("Overpayment Amount") against any payments due and payable by Anthem or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under the Agreement or under any Agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Anthem within thirty (30) calendar days of the date of the overpayment

refund notice from Anthem to the Provider or Facility. If the Overpayment Amount is not received by Anthem within the thirty (30) calendar days following the date of such notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by Anthem or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Anthem's procedures set forth in the Provider Manual, provided that such appeal shall not suspend Anthem's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

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## Pharmacy Home Program

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The availability and access to opioid medications used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when Members are on multiple controlled medications that are prescribed by multiple healthcare Providers. To address the growing opioid epidemic, Anthem implemented the Pharmacy Home Program in April 2016 to allow for better administration of drug benefits through increased communication and coordination amongst prescribing physicians and pharmacies. The information in this section applies to Anthem Members with Anthem's prescription drug coverage.

The Pharmacy Home Program helps reduce potential overutilization of controlled substance medications. If a Member is believed to be at an increased safety risk due to the overutilization of multiple controlled substance medications, from multiple Providers and/or pharmacies; and they meet enrollment criteria they may be included in this program. Anthem is able to increase communication and coordination amongst prescribing physicians for Members that have been identified and restricted to a single pharmacy. The pharmacy is selected by the Member and/or is assigned based on the retrospective Drug Utilization Review ("DUR") of their prescription Claims history. Following the selection of the Member's new Pharmacy Home, all of the Member's prescribing physicians receive notification of the Member's enrollment into the program, the assigned pharmacy information and a 3-month prescription profile containing a list of all prescribers, medications, dosages, and quantities received by the Member during that timeframe.

The program is designed to limit a qualifying Member to the use of one specific participating pharmacy for all prescribed Schedule II-V controlled medications for a period of no less than 12 consecutive months. This assigned pharmacy, or Pharmacy Home, will fill the Member's controlled substance medications throughout the term of their enrollment in this program.

### **The Pharmacy Home Program includes:**

- Reimbursement of controlled substance Claims when filled at the Member's Pharmacy Home. All controlled substance Claims are denied if filled at any pharmacy other than the Member's assigned Pharmacy Home<sup>1</sup>.

- Temporary overrides for urgent prescriptions.
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

### **Criteria**

A Member whose prescription Claims' history shows they meet the below inclusion criteria may be enrolled in the Pharmacy Home Program if <sup>2</sup>:

- The Member received five or more controlled substance prescriptions (government-regulated drugs) in a 90-day period.
- The Member received controlled substance prescriptions from three or more prescribers in a 90-day period.
- The Member visited three or more pharmacies to fill controlled substance prescriptions in a 90-day period.

<sup>1</sup> Both controlled and non-controlled medications must be filled at the designated Pharmacy Home.

<sup>2</sup> A Member may change the designated pharmacy only if the request meets good cause criteria.

<sup>3</sup> Exemption of Members with a diagnosis of Cancer, HIV, Multiple Sclerosis, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy Claim history and medical diagnosis.)

### **Communications to Members meeting criteria**

Members who meet criteria are sent a notification at least 60-days prior to potential inclusion in the program. After a 60-day monitoring period, if the Member continues to meet the program criteria during that timeframe, he/she is contacted in writing of the decision to place him/her into the Pharmacy Home Program. The Member will then be given 30 additional days to select a Pharmacy Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy Home within the allotted timeframe, one will be chosen for the Member on the 31<sup>st</sup> day based on pharmacy Claims. Anthem will ensure both the Member and their Provider will be notified of their new Pharmacy Home in writing. Once they have chosen a Pharmacy Home, a request to change pharmacies will be considered only for good cause situations.

Anthem is more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save lives. For questions or comments regarding enrollment, contact the Member Services number located on the back of the Member's ID card.

<sup>1</sup> A Member may change the designated pharmacy only if the request meets good cause criteria.

<sup>2</sup> Exemption of Members with a diagnosis of Cancer, 2<sup>nd</sup> degree burns, 3<sup>rd</sup> degree burns, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy Claim history and medical diagnosis.)

# Product Summary

## **ACA-compliant health plans**

The affordable Care Act (ACA) applies to individuals and small group health plans. These plans can be purchased from the state's Health Insurance Marketplace, which is commonly referred to as the exchange. Plans can also be purchased off the exchange from traditional sources, such as sales agent.

## **BlueChoice PPO**

BlueChoice PPO is the name of Anthem's PPO product. BlueChoice PPO provides in-Network benefits and out-of-Network benefits; the Member has the option to choose either a preferred Provider or Facility and have benefits paid at the higher in-Network benefit rate, or a non-preferred Provider and have benefits paid at the lower out-of-Network benefit rate.

## **BlueChoice HMO**

BlueChoice Healthcare Plan is the name of the HMO product. This plan is built on the PCP model, emphasizing the PCP as the coordinator of a Member's health care. Physicians in the following specialties are eligible PCPs:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

BlueChoice HMO plan is designed to keep Members healthy. When illness occurs, the plan provides for quality care in the most appropriate setting at an affordable cost to employers and Members. Members have the freedom to select their PCP from a panel of Providers. The PCP provides and arranges all necessary medical services, including preventive care and treatment for illnesses and injuries. The PCP also coordinates referral specialist services and hospitalizations among Providers

## **BlueChoice Option**

BlueChoice Option is the name of the Point of Service (POS) product. A POS plan is a hybrid of an HMO and traditional indemnity coverage. What distinguishes a POS plan from an HMO plan is the inclusion of out-of-Network benefits.

BlueChoice Option Members are considered in-Network when they access all healthcare services through their designated PCP and use the services of a Network Provider. If a Member uses out-of-Network services that are not coordinated by the PCP, his or her benefits are paid at a lower rate, which results in higher out-of-pocket expenses.

## **Blue Open Access**

Blue Open Access is the name of the next generation Open Access product. Blue Open Access Members are not required to select a PCP and are able to access specialty care through a BlueChoice HMO Specialty Care Physician without a referral from a PCP. Members will be encouraged to establish or maintain a relationship with a PCP, since that physician would be most knowledgeable of the Member's medical history.

Blue Open Access Members will have a specifically branded Member ID card designating them as an Open Access participant. The card will include copayment amounts along with the standard benefit information included on all Member ID cards.

### PPO Network Overview

Network	Product Name	Description	PCP Referrals	Out of Network Benefits	Out of State Access
PPO	BlueChoice PPO	<ul style="list-style-type: none"> <li>No PCP Selection Required</li> <li>No Specialist Referrals Required</li> <li>INN and OON Benefits</li> <li>*BlueCard Program for Traveling Members</li> </ul>	No	Yes	Yes
	Anthem Lumenos PPO	<ul style="list-style-type: none"> <li>PPO Consumer Driven Healthcare Product</li> <li>No PCP Selection Required</li> <li>No Specialist Referrals Required</li> <li>INN and OON Benefits</li> <li>*BlueCard Program for Traveling Members</li> </ul>			
	Blue Essential PPO	<ul style="list-style-type: none"> <li>PPO Hospital/Surgical Product</li> <li>Limited Benefit Coverage</li> <li>No PCP Selection Required</li> <li>No Specialist Referrals Required</li> <li>INN and OON Benefits</li> <li>*BlueCard Program for Traveling Members</li> </ul>			

### HMO Network Overview

Network	Product Name	Description	PCP Referrals	Out of Network Benefits	Out of State Access
HMO/ PPO	Blue Open Access HMO	<ul style="list-style-type: none"> <li>HMO Open Access Product</li> <li>No PCP Selection Required</li> <li>No Specialist Referrals Required</li> </ul>	No	No	Out of Network benefits are not available, except in Emergencies
	Blue Essential Open Access HMO	<ul style="list-style-type: none"> <li>HMO Open Access Hospital/Surgical Product</li> <li>Limited Benefit Coverage</li> <li>No PCP Selection Required</li> <li>No Specialist Referrals Required</li> </ul>			
	Blue Open	<ul style="list-style-type: none"> <li>POS Open Access Product</li> <li>No PCP Selection Required</li> <li>No Specialist Referrals Required</li> </ul>		Yes	Yes

Network	Product Name	Description	PCP Referrals	Out of Network Benefits	Out of State Access
	Access POS	<ul style="list-style-type: none"> <li>• INN and OON Benefits</li> <li>• *Blue Card Program for Traveling Members (eff 1/1/10)</li> </ul>			
	Blue Essential Open Access POS	<ul style="list-style-type: none"> <li>• POS Open Access Hospital/Surgical Product</li> <li>• Limited Benefit Coverage</li> <li>• No PCP Selection Required</li> <li>• No Specialist Referrals Required</li> <li>• INN and OON Benefits</li> <li>• *Blue Card Program for Traveling Members (eff 1/1/10)</li> </ul>			
	Anthem Lumenos Open Access POS	<ul style="list-style-type: none"> <li>• POS Open Access Consumer Driven Healthcare Product</li> <li>• No PCP Selection Required</li> <li>• No Specialist Referrals Required</li> <li>• INN and OON Benefits</li> <li>• *Blue Card Program for Traveling Members (eff 1/1/10)</li> </ul>			
	BlueChoice HMO	<ul style="list-style-type: none"> <li>• HMO Product</li> <li>• Requires PCP Selection</li> <li>• Requires Specialist Referrals</li> <li>• INN Benefits Only, Except in Emergencies</li> </ul>	Yes	No	Out of Network benefits are not available, except in Emergencies
	BlueChoice Option POS	<ul style="list-style-type: none"> <li>• POS Gatekeeper Product</li> <li>• Requires PCP Selection</li> <li>• Requires Specialist Referrals</li> <li>• INN and OON Benefits</li> </ul>		Yes	Yes

## Health Insurance Marketplace (Exchanges)

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as exchanges) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans.

Anthem offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.



Updates about Anthem's ACA compliant health plans and the networks supporting these plans are published in Anthem's Provider newsletter and sent via Anthem's email service. To sign up for Provider Communications for Georgia, go to <https://messageinsite.com/networkupdate>.

Additional information and current communications about Health Insurance Exchanges can be found from the Provider homepage at <http://anthem.com/>.

**Important reminder:**

Providers and Facilities are able to confirm their participation status by using the Find a Doctor/Find Care tool. See the **Online Provider Directory & Demographic Data Integrity** section for more details.

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## Federal Employees Health Benefits Program ("FEHBP")

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### FEHBP PROGRAM REQUIREMENTS

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employees Health Benefits Program ("FEHBP"). The Anthem FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as "Federal Employee Program®" or "FEP®", – the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and/or other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility Agreement or this Provider Manual and the rules, regulations, and/or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control.

When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

### SUBMISSION OF CLAIMS UNDER THE FEHBP

All Claims under the FEHBP must be submitted to Plan for payment within the timeframe listed in the Provider or Facility Agreement. This timeframe applies from the date of discharge or from the date of the primary payer's explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to Anthem or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the timeframe will not begin to run until Provider or Facility receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after the timeframe indicated in the Agreement. Except where the Member did not provide Plan identification, Provider and Facility shall not bill, collect, or attempt to collect from Member for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.



## **ERRONEOUS OR DUPLICATE CLAIM PAYMENTS UNDER THE FEHBP**

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made within five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

## **COORDINATION OF BENEFITS FOR FEHBP**

In certain circumstances when the FEHBP is the secondary payer and there is no adverse effect on the Member, the FEHBP pays the local Plan allowable minus the Primary payment. The combined payments, from both the primary payer and FEHBP as the secondary payer, might not equal the entire amount billed by the Provider or Facility for covered services.

## **FEHBP WAIVER REQUIREMENTS**

- Notice must identify the proposed services.
- Inform the Member that services may be deemed not medically necessary or experimental/investigational, by the Plan
- Provide an estimate of the cost for services
- Member must agree in writing to be financially responsible in advance of receiving the services; otherwise, the Provider or Facility will be responsible for the cost of services denied

## **FEHBP MEMBER RECONSIDERATIONS AND APPEALS**

There are specific procedures for reviewing disputed Claims under the Federal Employees Health Benefits Program. The process has two steps, starting with a review by the local Plan (reconsideration), which may lead to a review by the Office of Personnel Management ("OPM").

The review procedures are designed to provide Members with a way to resolve Claim disputes as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Members. The local Plan and OPM do not accept requests for review from Providers or Facilities, except on behalf of, and with the written consent of, the contract holder or Member.

Providers and Facilities are required to demonstrate that the contract holder or Member has assigned all rights to the Provider or Facility for that particular Claim or Claims.

When a Claim or request for Health Services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the Member, contract holder or their authorized representative. The request for review must be received within six months of the date of the Plan's final decision. If the request for review is on a specific Claim(s), the Member must be financially liable in order to be eligible for the disputed Claims process.

The local Plan must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical

records and nurses' notes, related to the Claim. If the additional information is not received within 60 calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Member's request, the Plan will advise the Member of his/her right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM. Only the Member or contract holder may do so, as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.

## FEHBP FORMAL PROVIDER AND FACILITY APPEALS

Providers and Facilities are entitled to pursue disputes of their **pre-service request** (this includes pre-certification or prior approval) or their **post-service Claim** (represents a request for reimbursement of benefits for medical services that have already been performed), by following a formal dispute resolution process.

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 180 days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan's notification letter.

The request for review may involve the Provider or Facility's disagreement with the local Plan's decision about any of the **clinical issues** listed below where the Providers or Facilities are *not* held harmless. Local Plans should note that this list is not all-inclusive.

1. not medically necessary (NMN);
2. experimental/investigational (E/I);
3. denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
4. precertification of hospital admissions; and,
5. prior approval (for a service requiring prior approval under FEHBP).

Not all benefit decisions made by local Plans are subject to the formal Provider and Facility appeal process. The formal Provider and Facility appeal process does not apply to any non-clinical case.

When a Claim or request for services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six months of the date of the local Plan's final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the Claim. If the additional information is not received within 60 calendar days, the local Plan will make its decision based on the information available.

Appropriate medical review will also be done at this time. Even if the local Plan does not completely satisfy the Provider or Facility's request, the formal Provider and Facility appeal process is complete; no additional appeal rights are available.

## **FEHBP INPATIENT SKILLED NURSING FACILITY CARE**

- Effective January 1, 2018 benefits are available for up to 30 days of inpatient skilled nursing Facility ("SNF") care per benefit year for Standard Option Members who are not enrolled in Medicare Part A.
- Hospitals and Plan staff must be proactive in identifying Members for whom a SNF stay is an appropriate level of care in the continuum toward transition home.
- The Member must be enrolled in case management ("CM") and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the hospital discharge planning staff collaborate with the Plan case manager, and in some cases, will necessitate the hospital case manager/discharge planner's assistance in delivering the consent to the Member and having it returned to the Plan after the Member/proxy signs the document.
- The transferring Facility must submit a detailed description of the Member's clinical status and the proposed treatment plan for the Plan's review of the proposed admission.
- Once the Member is admitted and subsequently within the timeframes established by the Plan, the SNF representative must provide specific information regarding the Member's status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the Member from achieving the goals.
- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 72 hours of the Member's admission. Members admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the Facility 24 hours/day.
- Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 1 hour of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to the Plan to document therapy time).

## **ONLINE INFORMATION FOR FEHBP**

Refer to the benefits and services on the FEHBP Web Site <https://www.fepblue.org/> for additional information.

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# **BlueCard Program Overview**

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BlueCard is a national program that enables Members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare Providers and Facilities with the independent Blue Plans across the

country and in more than 200 countries and territories worldwide through a single electronic network for Claims processing and reimbursement. The program allows Providers and Facilities to submit Claims for Members from other Blue Plans, domestic and international, to Anthem. Anthem is the sole contact for Claims payment, adjustments and issue resolution.

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online go to [anthem.com](https://www.anthem.com), select **Providers**, select **Policies, Guidelines & Manuals**, scroll down and select “**Download the Manual**”, scroll to the **Provider Manual Library** section and choose **BlueCard Provider Manual**.

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## Medicare Advantage

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Refer to the Medicare Advantage website for additional information at [www.anthem.com/medicareprovider](https://www.anthem.com/medicareprovider)

Medicare Advantage Provider Manuals are available on Anthem.com. Select **Provider** then **choose Policies, Guidelines and Manuals** under the horizontal menu, scroll to the **Provider Manual** section and select **Download the Manual**. Scroll to the **Provider Manual Library** section and choose **Medicare Advantage Provider Manual**.

- [Medicare Advantage Provider Guidebook](#)

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## State Health Benefit Plan

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Anthem is excited to continue servicing the Georgia State Health Benefit Plan (SHBP).

State Health Network = SHBP

The State Health Network = SHBP for HRA Plans and HMO plan (active Members/early retirees):

In Georgia = Open Access POS Network

Outside of Georgia = BlueCard® National PPO Network (for traveling benefits)

### Communications

Anthem added a SHBP specific section to the bi-monthly Provider newsletter, [Network Update](#). Anthem will also email late breaking important information via Network eUpdate. Providers and Facilities not yet registered to receive Network eUpdate should do so by visiting the Communications page of [Anthem.com](https://www.anthem.com), or contacting a Provider Representative for help.

### Precertification

SHBP requires precertification for some services that are not required for non-SHBP Members. This revised precertification list [SHBP Prior Authorization](#) and the [SHBP page](#) on [Anthem.com](https://www.anthem.com). Providers must obtain precertification for the services listed in order to receive reimbursement. Future notifications of changes to the posted precertification list will be done through Network Update and posted to the Precertification page and the SHBP page [Anthem.com](https://www.anthem.com).

### **AIM Specialty Health<sup>SM</sup> (AIM) Programs**

AIM programs include management of high-tech imaging, echocardiography, specialty pharmacy, radiation therapy and sleep studies and sleep therapy/treatment. All of these services require precertification. In addition, for Providers of high-tech imaging services, sleep testing and sleep therapy/treatment, AIM requires the completion of an OptiNet<sup>SM</sup> online site assessment. The following AIM programs apply to SHBP:

- Diagnostic Imaging Program
- Imaging Cost and Quality Program
- Outpatient Radiation Therapy Program
- Sleep Management Program
- AIM Enhanced Cardiology Program

More information on the AIM programs can be accessed on the [Answers@Anthem](#) page, the [Precertification page](#) on [Anthem.com](#), by visiting AIM's website at [aimspecialtyhealth.com](#), or calling 800-252-2021.

### **Specialty Pharmacy**

SHBP has contracted directly with CVS Caremark as its pharmacy vendor; however some of the pharmaceuticals may be covered under the Member's medical benefit.

### **Claim Processing**

Certain benefits, as defined by SHBP, will require specific standard industry codes in order for the service to be considered a covered benefit.

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## **Gatekeeper HMO Specific Guidelines**

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### **ROLE OF THE PRIMARY CARE PHYSICIAN**

The primary care physician ("PCP") is responsible for providing care within the scope of his or her practice and managing all other aspects of the Member's medical care. This includes coordinating notifications for Member referrals to specialists and obtaining pre-authorizations for hospital admissions. PCPs also confer with specialists about admissions recommended by a specialist. For BlueChoice HMO/Blue Choice Option Members, the PCP will coordinate referrals for specialty care and inpatient admissions, either directly or in collaboration with a specialist.

Specifically, the PCP will:

- Serve as the Member's personal physician, providing services and treatment without discrimination
- Provide all primary care services in a manner consistent with customary and recognized standards
- Coordinate and manage all other medical services
- Notify Anthem about referrals to in-network specialists
- Obtain pre-authorizations for inpatient admissions

- Obtain pre-authorizations for outpatient procedures
- Refer and admit only within the Anthem network
- Comply with required Anthem procedures
- Accept Anthem reimbursement
- Provide 24-hour, 7-day a week access to medical care for Members

For BlueChoice HMO, BlueChoice Option (“POS”) Individuals, PCPs should follow these procedures for office services:

- Verify Member eligibility and PCP assignment (via [www.availity.com](http://www.availity.com))
- Provide care
- Collect co-payment
- File CMS 1500 Claim form

NOTE: Nothing in this manual is intended to supersede or substitute for the PCP’s judgment about what is in the Member’s best medical interest.

## **MEMBER SELECTION OF A PCP**

When a Member enrolls in the BlueChoice HMO or BlueChoice Option, he or she will select a PCP from the Anthem Provider Network. Members may change their PCP by notifying Anthem and changes become effective on the first day of the following month if the change is received by the 25th of the month. If the change occurs after the 25th, it will be effective on the first day of the subsequent month.

## **PCP SCOPE OF SERVICES**

Anthem wants to ensure that Members receive continuous, appropriate health care in accordance with the physician’s network participation Agreement. Anthem also want to ensure that each PCP has the generally acceptable skills necessary to care for common primary care medical conditions. Accordingly, Anthem requires network physicians to meet and comply with the following criteria in their scope of practice.

The PCP will coordinate all aspects of Members’ care, including generating referrals to network specialists and plan notification for POS Members.

The PCP will coordinate, monitor and ensure the continuity of a Member’s care after a referral is approved.

The PCP will seek prior authorization for non-participating Provider referrals, except in an emergency. This includes out-of-network specialists, ancillary and Facility Providers.

The PCP will use designated laboratory, radiology, specialist physicians, ancillary and Facility Provider networks as outlined in this manual or designated local region communications.

The PCP will comply with the Anthem quality assurance and utilization management initiatives and related policies and procedures.

These include:

- Requesting practice closure to new Members as stated above and providing written notification to Anthem at least 90 calendar days in advance of the anticipated closure;

- Reporting all patient encounters, including all applicable diagnosis (ICD-10 or successor codes) and procedure (CPT IV) codes;
- Collecting Member copayments at each visit;
- Acknowledging the PCP of record is responsible for a Member's care (including emergency care) even if the Member has not been treated in the office;
- Cooperating with medical record and site survey processes;
- Obtaining prior authorization for inpatient medical admissions, except emergencies;
- Providing 24-hour, 7-day per week access to primary care services – or providing a covering physician. (Members should go to the emergency room only if an emergency condition exists. Use of urgent care centers will be based on Anthem's policy and referral requirements.)
- Prescribing generic equivalent drugs when possible and using the Preferred Drug List when applicable (see [www.Anthem.com](http://www.Anthem.com));
- Accepting reimbursement as detailed in the PCP network participation Agreement.

The PCP will provide comprehensive, continuous medical and preventive care appropriate to the age range of the practice's specialty.

This care will include, but not be limited to:

- Newborn care, including hospital-based
- Infant care
- Children's care
- Adolescent care
- Adult care
- Elderly care
- Periodic health assessment and physical exams in accordance with the established Preventive Health Guidelines, including interventions, immunizations and screenings
- Patient education and counseling
- Health promotion counseling, including injury prevention
- Well-woman exams
- Family planning
- Nutrition counseling
- Drug and tobacco counseling
- Cancer screening
- Screening for heart disease
- Emergency and urgent care triage
- Ambulatory, hospital and home care
- Note: A PCP may coordinate inpatient hospital care through an in-network hospitalist.



- Nursing home and hospice care
- Treatment for acute illness, including:
  - Musculoskeletal (fibromyalgia, tendonitis, etc.)
  - ENT (sinusitis, otitis media, etc.)
  - Ophthalmic (corneal abrasion, conjunctivitis, etc.)
  - Dermatologic (scabies, pediculosis, etc.)
  - Infectious (cellulitis, pneumonia, etc.)
  - Gynecological (vaginitis, etc.)
  - Urologic (urinary tract infection, etc.)
- Gastrointestinal
- Cardiovascular
- Neurological
- Pulmonary
- Treatment for chronic illnesses, including:
  - Cardiovascular (angina, hypertension, stroke, etc.)
  - Endocrine (diabetes, thyroid disease, etc.)
  - Musculoskeletal (rheumatoid arthritis, osteoarthritis, etc.)
  - Pulmonary (asthma, bronchitis, emphysema, etc.)
  - Skin (acne, dermatitis, etc.)
  - Gastrointestinal (ulcer, irritable bowel, etc.)
  - Genitourinary (urinary incontinence, etc.)
- Identifying and recommending treatment for depression, anxiety disorders, stress, grief reaction
- Identifying and recommending treatment for substance abuse
- Comprehensive assessment
- Evaluation of occupational and school health-related illnesses
- Death and dying counseling
- knowledge about interdisciplinary resources and Community and public health resources
- Managed care practice management, including cost-effective care and appropriate use of consultants
- Risk management

The PCP will provide for or coordinate the following in-network or approved out-of-network interventions in the appropriate ambulatory setting:

- EKGs



- Routine sigmoidoscopy
- Injections and immunizations
- Allergen immunotherapy injections
- Vision and hearing screening
- Routine lab work (UA, FBS, HCt, rapid strep, etc.)
- Radiology
- 24-hour holter monitor
- Minor surgery, including laceration repair

## **TERMINATING A PHYSICIAN-PATIENT RELATIONSHIP**

A PCP may request that a Member be removed from his or her patient list. Members selecting a PCP are responsible for making a positive contribution to the physician-patient relationship. If an effective physician-patient relationship cannot be established, the PCP may discharge a Member from his or her care.

After receiving approval to terminate the relationship, the PCP must:

- Provide written notice via Certified Mail to the Member explaining the intention to discharge the Member from his or her patient list.
- Advise the Member to select another PCP. The Member may log on to [www.Anthem.com](http://www.Anthem.com) or contact Anthem's customer service department to select another PCP.
- Send a copy of the notice to Anthem Provider representative.
- For thirty (30) calendar days, the PCP is required to provide health care services to the Member until the Member has selected another PCP.

## **ACCESS STANDARDS**

Anthem has developed the following standards to ensure that Members have timely access to medical care:

### **Office hours**

A physician's office must be open at least four (4) days per week. If a PCP has more than one office, he or she must be available to Anthem Members a total of four (4) days per week. The PCP must directly provide at least twenty (20) hours of in-office patient care per week. If he or she has more than one (1) office, the PCP must be available to Anthem Members for a total of twenty (20) hours per week.

### **Appointment availability**

- An appointment for a periodic health assessment for preventive care must be scheduled within sixty (60) calendar days of a Member's initial call or ninety (90) days for OB/GYN.
- An appointment for a routine office visit (such as follow-up, blood pressure and weight checks, prescription refills, etc.) must be scheduled within fourteen (14) days of a Member's initial call – or within thirty (30) days for OB/GYN – or ten (10) business days for Behavioral Health.

- For emergent diagnoses, PCPs must provide same-day appointments. Behavioral Health Providers must be available to assess a patient experiencing an emergent situation within six (6) hours.
- For urgent diagnoses, appointments must be available within twenty-four (24) hours. Behavioral Health Providers must be available to assess a patient experiencing an urgent situation within forty-eight (48) hours.
- Same-day appointments must be available depending on the urgency of the Member's complaint.

#### **After hours coverage**

- Twenty-four (24) hours/seven (7) days a week on call coverage
- Physician to call back within two (2) hours
- Covering physicians must be Anthem network physicians
- On-Call physician should provide triage for urgent/emergency care

#### **Office wait time**

Office wait time for a scheduled appointment is thirty (30) minutes or less. If the wait time will likely be more than thirty (30) minutes, the Member has a choice of waiting or rescheduling the appointment.

#### **Telephone access**

- Incoming phone calls to the Provider's office must be answered within ten (10) rings
- Office staff should ask permission to place callers on hold before doing so. If a caller is placed on hold, the call will be acknowledged every two minutes.
- The physician must provide coverage twenty-four (24) hours, seven (7) days-a-week for appropriate triage.

## **ROLE OF THE SPECIALTY CARE PHYSICIAN**

Anthem PCPs refer Members of Anthem to specialists who participate in the Anthem Network\*. Except in emergency situations, Members' specialty care must be coordinated through their PCP. PCPs are required to refer Members only to HMO participating specialists. These specialists work with the Member's PCP and recognize the PCP's role as manager of all the Member's medical care. Members covered under a Point-of-Service ("POS") plan have benefits available for out-of-network services.

\* Note: A referral from a PCP is not required for Behavioral Health Services. Members may self-refer by calling the telephone number on their Member identification card. HMO and Point-of-Service Members do not have out-of-network benefits for Behavioral Health Services and must obtain services from a Participating Provider.

#### **Responsibilities of the Specialist**

After confirming that the PCP has notified Anthem of the referral, the specialist's responsibilities include:

- Confirm a valid referral has been obtained from the PCP (when required) before rendering services to Anthem Members

- Providing appropriate, necessary medical services to the Anthem Member
- Communicating findings and recommended treatment to the PCP in a timely manner
- Consulting with the Member's PCP before recommending further specialty care or referring the Member to another specialist
- Complying with Utilization Management and Quality Assurance programs as required by Anthem
- Obtaining prior authorization for all hospital admissions, with concurrence of the PCP
- Accepting the Member's BlueChoice ID card and co-payment in lieu of full payment at the time of service
- Accepting reimbursement as payment in full from Anthem as specified in the Agreement as payment in full from Anthem.
- Billing Anthem Members only for applicable Cost Shares

### **Specialist Physician Guide**

Specialists should use the following guidelines when providing services to BlueChoice Members:

#### **Verify Member eligibility**

- Check the Member's ID card
- Verify eligibility online at [www.availity.com](http://www.availity.com) or
- Call Anthem for confirmation of coverage and benefits

#### **Ensure proper referral**

- Verify the referral has been obtained via online at [www.availity.com](http://www.availity.com).
- If a referral notification cannot be confirmed, inform the Member that he or she may be responsible for all or part of the bill for the specialist's services. The specialist may then contact the PCP, or direct the Member to seek referral notification through the PCP and Anthem.
- Secure authorization from the PCP for additional consultations or services beyond what was initially authorized for a specific condition.

### **Direct Access Specialists**

Ophthalmology, Optometry, OB/GYN, and Dermatology are considered direct access specialties to which Members are entitled to refer themselves to in-network specialists. (No referral from the PCP is necessary.) Covered services are limited to those associated with each Provider specialty and are subject to Anthem utilization management guidelines.

PCP referral is not required for a Member to access outpatient or inpatient mental health and substance abuse services. The Member Health Benefit plan requires that Provider s render services. Behavioral health Providers are strongly encouraged to provide PCPs with updates regarding treatment progress and medication usage.

### **SPECIALIST TO SPECIALIST REFERRAL**

Specialists **may refer** patient to other specialists for Covered Services **only in the following circumstances:**

- OB/GYNs may refer to:
  - any in-network specialist if the Member is pregnant
  - in-network general surgeon or interventional radiologist for breast mass
  - in-network GYN-Oncologist or Infertility Specialist
- Orthopedists/Neurologists/Neurosurgeons and Rheumatologists may refer to physical therapy.
- Orthopedists may refer to Neurologist for nerve conduction studies (testing only).
- Orthopedists may refer to Physical Medicine and Rehabilitation specialists.
- Specialists may refer Member for diagnostic testing, additional visits, and inpatient and outpatient admission after consulting with PCP.

All other referrals must be submitted by the PCP.

**Note: The ordering physician is responsible for the approval of tests that require precertification or notification.**

## **SELF-REFERRALS BY MEMBERS**

BlueChoice Option (POS) Members may self-refer to any in-network or out-of-network Provider and receive services at a significantly reduced benefit level, except in the following cases:

- Preventive Care is covered only if performed by the Member's PCP (except mammogram, Pap smear, prostate antigen test, and child wellness from birth through age five).
- Behavioral Health Services (Mental Health and Substance Abuse) are not covered if rendered by an out-of-network Provider.
- Non-emergency use of the emergency room is not covered.

BlueChoice Option Members must use Provider s for all services to receive in-network benefits. However, they may also self-refer to an out-of-network specialist (for services not listed above) and be subject to a reduced out-of-network benefit level.

BlueChoice HMO Members may self-refer to the following specialists:

- OB/GYNs for annual well-woman exam and any OB/GYN-related medical conditions including pregnancy termination.
- Dermatologist for any related medical conditions.
- Optometrist/Ophthalmologist for consultation of medical conditions of the eyes.
- Behavioral Health Providers for Mental Health and Substance Abuse services.
- Oral Surgeons for impacted wisdom teeth.

BlueChoice HMO Members must use Network Providers to receive benefits for these services.

## **OB/GYN SPECIFIC INFORMATION**

### **Well Woman Exams**

BlueChoice HMO/BlueChoice Option provides coverage for one routine gynecological examination per contract year for all women Members pending group benefit specifics.

By the Member's choice, the well woman examination may be performed by either the Member's PCP or a participating Obstetrician or Gynecologist.

Providers are to bill for well woman services using any office CPT code listed below and the ICD-10 or successor codes V72.3 in any of the diagnostic fields on the professional Claim form.

Office/Preventive Visit: 99201-99215, 99384-99387, 99394-99397

BlueChoice HMO/BlueChoice Option benefits cover only the services listed below, depending on group-specific benefit levels, when part of the well woman examination:

- Medical/Gynecologic history of the Member
- Physician examination of the breast and pelvic organs
- Pap smear through contracted ancillary laboratory (LabCorp)
- Microscopic examination of the vaginal smear through contract ancillary laboratory (LabCorp)
- Treatment of incidental vaginal infections (i.e. yeast, trichomonas, and non-specified infections)
- Rectal examination after age 40 years
- Birth Control administration
- Urinalysis (through LabCorp)
- Hematocrit (through LabCorp)

### **Mammogram**

Initial screening between 35- 40 years of age and then every one to two years between ages 40-50. Women over age 50 should have an annual mammogram. Mammograms may be done in a physician's office if the office is ACR accredited. Physicians who perform mammograms in their office are asked to bill a global fee. The office will be responsible for any reading or interpretation fees associated with the mammogram.

### **Contraceptive Management**

- Norplant removal
- Depo-Provera (per 150 me. Injection)
- IUD insertion
- IUD removal
- IUD contraceptive device
- Fitting of diaphragm/cap

### **Obstetrics Care**

Vaginal or C-Section delivery global fee includes the following:

- Comprehensive first visit
- All visits related to obstetrical care
- Non-stress test (times two)\*
- Ultrasound

- Lab work will be capitated
- Delivery: Vaginal or C-section
- Postpartum care (up to 8 weeks)

\* Maternity non-stress tests in excess of two per pregnancy per patient are not eligible for separate reimbursement unless such service is related to a problem-oriented diagnosis.

### **High Risk Obstetrics Cases**

- Gestational diabetes
- Pregnancy induced hypertension
- Pre-existing chronic illnesses such as SLE, renal disease, etc.
- Congenital anomalies affecting delivery or requiring immediate intervention
- Intrauterine fetal growth retardation

### **Miscarriage and Early Fetal Demise:**

- Will be reimbursed as fee-for-service

### **Past Twenty (20) Weeks:**

- Global fee will be paid

### **Referral and Preauthorization**

- Notify the Utilization Management Department of the Member's pregnancy. Precertification is not required for vaginal and C-section deliveries that do not exceed the mandated two (2) day or four (4) day inpatient stay. Any length of stay beyond those timeframes for vaginal (2 days) and C-section (4 days) deliveries must be precertified by the Utilization Management Department.

### **Surgical Assistants at C-Sections**

There has been much confusion over the terms Surgical Assistant versus Assistant Surgeons as they relate to C-sections. After careful review and input from both external consultants and local OB/GYNs, Anthem has clarified the definition and reimbursement for these services.

- Surgical Assistant: A technically skilled professional (not required to be MD) to assist during a surgical procedure.
- Assistant Surgeon: A licensed physician. Assistant surgeons are approved and reimbursed based on the medical necessity for an assistant surgeon during this procedure.

### **Group Specific Benefits**

Verify Member benefits to determine if there are group specific benefits for the employer group.

#### **Emergency services**

- Contact the PCP, if practical
- If the situation is a true emergency, treat the patient, then contact his or her PCP
- Contact the PCP and Anthem within 24 hours of emergency admissions

#### **File Claims for Members**

- Mail Claims to address on back of Member ID Card
- Submit CMS 1500 to Anthem
- Accept Anthem reimbursement
- Collect deductible, co-insurance and co-payments from the Member

## **COVERING PHYSICIAN(S)**

The PCP must be available and accessible to provide or coordinate all health care services for Members (including but not limited to emergency medical care, outpatient services and inpatient hospital services) twenty-four (24) hours per day, seven (7) days per week, either directly or through an appropriate call system providing for timely callback. In the event the PCP cannot provide these services personally, the call coverage must be provided through another Network physician ("Covering Physician").

PCPs are reimbursed either on a monthly capitation fee or fee for service basis to provide health care services to Members. When the capitated PCP arranges for a Covering Physician, who is also reimbursed on a capitation basis, to provide call coverage, the PCP is responsible for making arrangements to pay the Covering Physician. The Covering Physician may not bill Anthem for any health care services which are covered under the capitation fee because Anthem has already paid the PCP to provide those services. When a fee for service PCP arranges for a Covering Physician, who is also reimbursed on a fee for service basis, to provide call coverage Anthem will reimburse the Covering Physician according to the applicable fee schedule. The PCP is also responsible for ensuring that the Covering Physician (i) only bills a Member for (A) non-Covered Services which Member agrees to in writing BEFORE such services are provided, and (B) all applicable cost share amounts applicable to the Covered Services, and (ii) does not bill a Member for the difference between the Covering Physician's charges and the amount of compensation paid to the Covering Physician by the PCP (i.e., no balance billing).

## **MISSED PHYSICIAN APPOINTMENTS**

To receive reimbursement when a Member misses a set appointment time, Providers must first establish a written office policy addressing payment for missed appointments. Members should acknowledge their understanding of the policy in writing. Normally this can be accomplished with a one-time signature. Once the policy has been established and the Member has signed his or her acknowledgement, the follow guidelines apply:

- A Provider shall not collect a missed appointment fee unless the Member has signed a statement acknowledging understanding of the policy.
- Claim forms for missed appointments should not be submitted.
- Providers are encouraged to accept the Member's co-pay as the fee for missed appointments.
- Providers should report repeated missed appointments to Customer Service in order for Members to be effectively educated.
- If the Member continues to miss appointments and does not pay for them, the Provider has the right to request that the Member be removed from his or her patient list. (Refer to: Terminating a physician-patient relationship.)



## MEMBER COPAYMENT

Anthem Members are only responsible for a copayment amount for Covered Services provided by the PCP in his/her office. The copayment is printed on the Member's ID card.

A physician copayment may be collected for any visit at which a physician or healthcare professional sees a Member and an office visit CPT procedure code is filed on the Claim. **The copayment should not be collected if the Member is only assisted by the administrative staff (examples: picking up a prescription or requisition or drawing for laboratory tests).**

Group benefits may supersede the copayment allocation. Verify Anthem Member eligibility and benefits to determine the appropriate collection of the Member's copayment.

Note: Only one copayment may be collected for each patient visit. An additional copayment may be applicable for urgent care visits. Group specific benefit inclusions and/or exclusions will supercede Anthem standard Health Benefit plan structure. Copayment for flu vaccines is dependent on the Member's benefits as outlined in their Member Certificate Booklet. Verify Member eligibility and benefits to determine appropriate collection of Member copayment.

## PCP REIMBURSEMENT

PCPs are reimbursed either on a fee-for-service or capitation basis, in accordance with his/her Anthem PCP Agreement. Those PCPs who are reimbursed according to a capitation schedule receive a monthly payment equal to the capitation rate multiplied by the number of Anthem Members assigned to the practice. In addition to that monthly capitation payment, some procedures are separately paid on a fee-for-service basis.

Capitation payments are made on a full month basis only, and are never prorated. Member effective dates of eligibility and PCP changes are, therefore, normally the 1st of the month. Members may be added or cancelled up to sixty days retroactively.

In some cases Members will become effective on dates other than the first of the month (e.g. newborns). Capitation for Members with mid-month effective dates will be paid as follows:

Effective Date of Enrollment	Reimbursement
1st through 15th	Full capitation for month
16th through 31st	No capitation for first month

Also, Members may terminate coverage during the month (e.g. they terminate employment with the group who insures them). Capitation for Members with mid-month termination dates will be paid as follows:

Effective Date of Termination	Reimbursement
1st through 15 <sup>th</sup>	No capitation for final month
16th through 31 <sup>st</sup>	Full capitation for month



## ENCOUNTER REPORTING

All services provided to Anthem Members must be reported in the standard HIPAA compliant Claim format using HIPAA-compliant code sets on the CMS-1500 Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted. This is necessary for reporting of utilization data and HEDIS purposes. The Claim system will identify CPT codes eligible for fee-for-service payment and will approve those services when appropriate.

Remember to verify the Member's ID card on each visit to ensure Claims are submitted with the correct Member ID for that particular date of service. Electronic Claim submission still remains the most efficient way to submit Claims; however, if Providers and Facilities submit a hard copy Claim refer to the back of the Member's ID card for the appropriate Claim submission address and customer service number.

## DISCONTINUING ACCEPTANCE OF NEW PATIENTS

According to their contractual Agreement, PCPs are required to accept BlueChoice HMO or BlueChoice Option Members who select them as their PCP up to the practical limit set by their practice. As long as the physician's practice is generally open to new patients, he or she must be available for PCP selection by Members.

PCPs may close their practice to BlueChoice HMO and BlueChoice Option Members only if the practice is also closed to all new patients. To close the practice to new patients, PCPs must give 90 (ninety) days advance written notice to Anthem. The ninety (90)-day notice begins on the date Anthem receives a written document indicating the physician's intent to close the practice. The effective date will be the 91st day following receipt of the notice. PCPs must continue to accept new patients during the ninety (90)-day notice period.

Even if a physician's practice is closed to new patients, he or she must accept existing patients who convert coverage from another carrier to BlueChoice HMO or BlueChoice Option and choose the physician as their PCP.

When Anthem receives written notification that a physician's practice is closed to new patients, that information will be posted in the managed care system and at [Anthem.com](https://www.anthem.com). When the physician or physician's group is once again accepting new patients, the system will be updated and [Anthem.com](https://www.anthem.com).

Send the written notice about closing or reopening a physician practice to a Provider Experience Representative..

## CHANGES TO PRACTICE

Adding new physicians to the practice group – Participating PCPs shall provide Anthem with thirty (30) days prior written notice when their group adds or deletes physicians. New physicians joining a participating practice must submit a completed application along with contract documents. They must also meet all credentialing criteria required by Anthem to become a Member of the network.

Changing participation status – PCPs who wish to withdraw from the network must notify Anthem in writing one hundred (180) calendar days before the cancellation of the contract. The one hundred eighty (180) day period will begin on the date Anthem receives the written notice. Changes involving adding or discontinuing physicians from a practice, or changing participation status must be sent in writing to the local Provider representative.

## MEMBERS AND ENROLLMENT

### Enrollment Procedures

New BlueChoice Members must select a PCP from the panel of Providers. PCPs are physicians those who practice internal medicine, general practice, family practice, or pediatrics. Members must complete enrollment forms for themselves and all dependents. Each Member covered by the contract may choose a different PCP within the network. Anthem will notify the physician of his or her selection as a Member's PCP. Members may change PCPs by logging on to Anthem's website [www.Anthem.com](http://www.Anthem.com) or by calling Anthem customer service. PCP changes requested by the 25th of the month are effective the first day of the following month.

Physicians, who have questions about enrollment, Member eligibility, may verify this information at [availity.com](http://availity.com).

### PCP Practice Age Restrictions

The age range of patients seen by a PCP will be set as follows unless otherwise requested by the physician:

<b>Family Practice</b>	No restriction/will see patients of any age
<b>Internal Medicine</b>	Fifteen (15) years and older
<b>Pediatrician</b>	Newborn through age twenty (20) years

The PCP can establish age limitations for his/her practice, as long as those age limitations are applied equally to all managed care plans accepted by the PCP and adhere to the following standards:

- A Pediatrician is not to see an adult Member age twenty-one (21) years or older
- An Internal Medicine physician is not to see a child age fourteen (14) years or younger unless the physician has been approved by the Anthem Medical Director to see this age group.

### Member Identification and Eligibility

Each Member has an ID card that shows the Member's contract number and basic coverage information, including office visit co-payment. We urge physicians to keep a copy of the Member's ID card in the patient's office file and to verify Members and eligibility periodically.

Presenting a Member ID card does not guarantee eligibility, since Members may cancel their coverage at any time. Eligibility for benefits is determined by the Member's coverage status at the time of service.

When a Member arrives at the physician's office, he or she should present his/her Member ID card upon check in. If the Member seeks service before he or she has received a Member ID card the office staff may verify coverage at [availity.com](http://availity.com).

The office visit co-pay amount is listed on the front of the Member ID card. Co-payments may vary depending on the Member's Health Benefit Plan. Members should pay the indicated amount for each office visit.

If a Member with a Gatekeeper plan seeks service from a PCP who is not that Member's designated physician, the office staff should verify the Member's PCP by checking [www.availity.com](http://www.availity.com) or by calling the Provider Customer Service Information Line. The Member

should then be directed to the correct PCP's office. If the Member resists going to the designated PCP, he or she must understand that benefits either will not be available or they will be reduced to out-of-Network levels.

# Glossary

**65PLUS:**

65PLUS\* offers Medicare beneficiaries a choice of five of the federally approved Medicare supplement plans: Plans A, B, C, E and F. Because Medicare only pays a portion of hospital and physician charges, these supplements provide certain benefits otherwise unavailable from Medicare. *\*65PLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.*

**Accreditation:**

Certification that an organization meets the reviewing organization's standards. Examples: accreditation of HMOs by the National Committee for Quality Assurance ("NCQA") or accreditation of PPOs by URAC.

**Affiliate(s):**

Any entity owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or any entity which is under common control, with Anthem and that accesses the rates, terms or conditions of the Agreement. Anthem will have a current listing of such Affiliates available through a commonly available web site or upon request.

**American Accreditation HealthCare Commission, Inc./Utilization Review Accreditation Commission, Inc. (AAHCC/URAC):**

An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care Providers, consumers, and regulators to encourage more efficient and effective managed care.

**Ancillary:**

A term used to describe additional services performed related to care, such as lab work, x-ray, and anesthesia.

**Appeals:**

Refers to a formal written request (from a practitioner/Provider) for reconsideration of a decision previously made by Anthem during the complaint process, (e.g., benefit payment, administrative actions, etc.).

**Anthem Rate:**

The lesser of Facility's charges for Covered Services, unless otherwise defined, or the total reimbursement amount that Facility and Anthem have agreed upon as specified in the Plan Compensation Schedule (PSC). The Anthem Rate shall represent payment in full to Facility for Covered Services.

**Benefit:**

The amount payable by an insurer or employee benefit plan to a Claimant, assignee, or beneficiary under the terms of the Health Benefit Plan.

**Benefits Package:**

A term informally used to refer to the employer's benefit plan or to the benefit plan options from which the employee can choose. "Benefits package" highlights the fact a health benefits plan is a compilation of specific benefits.

**BlueChoice PPO:**

BlueChoice PPO is a preferred Provider organization (PPO) that offers Members the flexibility of going in or out-of-network for medical care. If Members see a physician, specialist or hospital that is in-network (a preferred Provider), they receive more savings and benefits. *\*BlueChoice PPO is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.*

**Board Certified (Boarded, Diplomat)**

Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

**Case Management:**

A method of coordinating and facilitating services and benefits Members receive to ensure they seek and receive appropriate and necessary care to minimize duplication of services, tests and costs and to maximize benefits available under their Member Agreement.

**Case Rate:**

The all-inclusive Anthem Rate for an entire admission or one outpatient encounter. Global Case Rate" means the all-inclusive Anthem Rate which includes institutional, professional and physician services for specific Coded Service Identifier(s).

**Certificate Booklet:**

A detailed document that serves both as an explanation of the benefit plan and as the certificate of insurance. See certificate of coverage.

**Certificate of Coverage:**

A description of the benefits included in an insurance plan. The certificate of coverage is required by state insurance laws and represents the coverage provided under the policy issued to the contract holder. The certificate is provided to subscribers via the Certificate Booklet.

**Chargemaster or Charges:**

Facility's listing of Facility Charges for products, services and supplies.

**Claim:**

Either the uniform bill Claim form or electronic Claim form in the format prescribed by Plan submitted by a Facility for payment by a Plan for Health Services rendered to a Member. "Complete Claim" means, unless state law otherwise requires, an accurate Claim submitted pursuant to the Agreement, for which all information necessary to process such Claim and make a benefit determination is included.

**Coded Service Identifier(s):**

A listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services (CMS) or other industry source, for reporting Health Services on

the UB-04 or its successor. The codes include but are not limited to, CPT-4, HCPCS, ICD-9 or successor codes, National Drug Code (NDC) and Revenue Codes, or their successors.

**Concurrent Review:**

A component of Utilization Management program which evaluates a Member's coverage for Facility services under the terms of the contract.

**Contract:**

A binding written Agreement between the insurer and policyholder to evidence the terms and conditions of the policy. The contract between Blue Cross and Blue Shield of Georgia and an insured includes the certificate booklet.

**Coordination of Benefits (COB):**

A provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-payment by insurance or duplication of benefits.

**Cost Share:**

With respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

**Member:**

Any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to the Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to the Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Member, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each is synonymous with any such other.

**Member ID Card:**

An identification card issued by PLAN or an Affiliate, which identifies an individual as a Covered Person. (The Member Card is for identification purposes only and may not be used as verification of eligibility.)

**Covered Services:**

Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Member is eligible.

**Credentialing:**

The process of reviewing a Provider's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for inclusion in a Network are met. Anthem screens all physicians in their Networks. Each physician must meet specific educational and medical practice standards in order to become part of the Network.

**Deductible:**

The amount of covered expenses that must be incurred and paid by each Member before benefits become payable by the insurer. For example, if a plan has a \$100 deductible, the deductible is met once the first \$100 of the covered medical expenses for that year has been paid. After that, the plan begins to pay toward the cost of covered health care services.

**Dependent:**

A covered person's spouse (not legally separated from the insured) and unmarried child(ren) who meet eligibility requirements.

**Discharge Planning:**

Component of Utilization Management program which evaluates a Member's coverage under the terms of the Member's contract for health care services after discharge from an inpatient setting.

**DRG:**

Diagnosis Related Group as set forth by the CMS or other grouper as may be used by Anthem and updated as codes are updated.

**Drug Formulary:**

A listing of prescription medications which are approved for coverage by the plan. The list is subject to periodic review and modification by the health plan.

**Eligibility:**

The provisions of the group policy or insurance contract that state the requirements that applicants must satisfy to become insured with respect to themselves or their dependents.

**Emergency Condition:**

A condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction to any bodily organ or part; or (4) other serious medical consequences.

**Employer Group**

A group of eligible employees to whom health care benefits are extended through a health benefits plan Provider. The relationship is formalized through a contract. For the employer group to be recognized, a true employee-employer relationship must exist. Examples of groups which would not qualify include social clubs and independent contractors.

**Exclusions:**

Specific conditions or circumstances listed in the Health Benefit Plan for which the policy or plan will not provide benefit payments.

**Facility Based Physician:**

Any physician, with the exception of residents, interns and fellows, who has a contractual relationship with a Facility to provide professional services. These services may be of two types: (1) administrative, managerial, teaching, or quality control activities compensated from or through a Facility which are furnished to a Facility or its general population; or (2) physician services

personally rendered to a Member while in a Facility which directly contribute to the diagnosis or treatment of a Member and which ordinarily require performance by a physician, including, an emergency room physician, radiologist, pathologist, and anesthesiologist, and any other physicians contracting with hospitals specified by Anthem, at any time, or from time to time; provided, however, that this term shall not include PCPs or Specialty Care Physicians employed by a Facility who have a separate contractual Agreement with Anthem.

**Fee-for-Service Reimbursement:**

A method of reimbursement by which a Provider charges, and is reimbursed, separately for each patient encounter or service rendered.

**Fee Schedule Rate:**

The Anthem Rate payable to Facility based on a specific Coded Service Identifier(s), as set forth in the applicable fee schedule(s).

**FEHBP:**

The “Federal Employee Health Benefit Program” is a group contract to provide health care benefits to federal employees, underwritten by Blue Cross and Blue Shield Plans. The official name of the program is the Government-Wide Service Benefit Plan.

**Group Health Coverage:**

A health benefits plan which covers a group of people as permitted by state and federal law.

**Guest Member:**

Members of an Affiliate of Anthem temporarily residing in a Service Area. Guest Member(s) will be treated as Anthem Members while present in a Service Area.

**Health Benefit Plan:**

The document(s) describing the partially or wholly: (1) insured, (2) underwritten, and/or (3) administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

**Health Service:**

Those services or supplies that a health care Facility is licensed equipped and staffed to provide and which it customarily provides to or arranges for individuals.

**HEDIS (Health Plan and Employer Data Information Set):**

HEDIS is a standard set of more than 100 indicators developed to assist purchasers/employers in evaluating health plans. HEDIS has become a standard of measurement for the Centers for Medicare and Medicaid Services (CMS), for some state insurance departments and for many large companies. HEDIS has also become a component of the NCQA accreditation process.

**Home Health Agency:**

A Facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide home health care services.

**Hospice:**

A Facility or program licensed or certified under law to provide palliative and supportive care for the terminally ill.



**Indemnity:**

Indemnity or “traditional” insurance is a plan which reimburses physicians for covered charges for services performed, or insures for medical expenses incurred.

**In-Network:**

In-network means seeing a Provider that has contracted with Anthem to participate in the network of physicians and hospitals.

**Inpatient Services:**

Covered Services provided by Facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the Facility, remains assigned to such bed and for whom a room and board charge is made.

**Length of Stay (LOS):**

The number of days that a Member stayed in an inpatient Facility.

**Managed Care:**

A health plan or insurance program in which beneficiaries receive medical service in a coordinated manner to eliminate unnecessary medical services. In managed care health plans, the Member seeks specialist or hospital care after prior approval of coverage by designated health care professionals, such as PCPs, utilization review nurses, or employer-designated professionals. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

**Medically Necessary or Medical Necessity:**

Covered Services or supplies provided by a Facility, physician, or other Provider to identify or treat an illness or injury and which, as determined by Plan, are: 1) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition; 2) compatible with the standards of acceptable medical practice in the United States; 3) not provided solely for the Member's convenience or the convenience of the physician, health care Provider or Facility; 4) not primarily custodial care; and 5) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

**Medicare:**

Title XVIII of the Social Security Act which provides payment for medical and health services to the population aged 65 and over regardless of income, as well as certain disabled persons and persons with ESRD.

**Member ID Card:**

A card given to each Member by Anthem which introduces the Member to physicians and hospitals. Although the cards do not guarantee eligibility for medical care benefits at any given time, they increase the convenience of obtaining health insurance services.

**NCQA:**

The National Committee for Quality Assurance is an independent, not-for-profit entity that works closely with the managed care industry, health care purchasers, researchers and consumers to develop standards for accreditation to determine whether a managed care organization is founded and practicing principles of quality and is continuously working to improve the services it provides. Typically NCQA auditors use these standards to evaluate managed care organizations with

regards to quality management and improvement, utilization management, credentialing, Member rights and responsibilities, preventive health services, and medical records.

**Network:**

A group of Providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Members are enrolled.

**Non-Participating Provider(s):**

A non-participating Provider is a physician, Facility or other medical Provider that has not entered into an Agreement with Anthem to provide health care services to Members.

**Observation:**

The services furnished by a Provider on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary after surgery or to evaluate an outpatient condition and determine the need for a possible admission to the Facility as an inpatient.

**Open Enrollment:**

A period when eligible persons can enroll in a health benefits plan.

**Other Payors:**

Persons or entities, utilizing the Networks/Plan Programs pursuant to an Agreement with Anthem or an Affiliate, including without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, self-administered or self-insured programs providing Health Benefit Plans, or employers or insurers.

**Outpatient Services:**

Covered Services other than Inpatient Services which are provided to a Member by Facility.

**Out-of-Pocket:**

Those medical expenses which an insured is required to pay because they are not covered under the group contract.

**Participation Attachment:**

The document(s) attached to, or made a part of the Agreement which identifies the additional duties and obligations related to Network(s) and/or Plan Programs.

**Patient Day:**

Each approved calendar day of care that a Member receives in the Facility, to the extent such day of care is a Covered Service under the terms of the Member's Health Benefit Plan, but excluding the day of discharge.

**Per Diem Rate:**

The Anthem Rate that is expressed as an all-inclusive fixed payment for each Patient Day of admission or one outpatient encounter.

**Physician's Current Procedural Terminology (CPT):**

A list of medical services and procedures performed by physicians and other Providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health

care industry's standard for reporting physician procedures and services, thereby providing an effective method of nationwide communication.

**Plan:**

Refers to (1) Anthem; (2) an Affiliate as designated by Anthem; and/or (3) Other Payor.

**Plan Compensation Schedule (PCS):**

The document(s) attached to, or made a part of the Agreement which set forth the Anthem Rate(s) for the Network(s) in which Facility participates.

**Plan Program:**

Any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association ("BCBSA") (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include but is not limited to, a health maintenance organization, a preferred Provider organization, a point of service product or program, an exclusive Provider organization, an indemnity product and program, and a quality program(s). The term Plan Program shall not include any program excluded by Plan or BCBSA.

**Point-of-Service:**

A managed care product that offers the advantages of an HMO with the flexibility of a traditional health insurance plan. Members decide where to receive care when they need it at the point-of-service.

**Pre-admission Review:**

A component of a Utilization Management program which reviews an inpatient Facility stay prospectively to determine coverage.

**Preauthorization:**

A prospective process to verify coverage of proposed care, to establish covered length of stay and to set a date for concurrent review.

**Preferred Provider Organization (PPO):**

A Network of facilities and physicians who agree to participate in a PPO Network. Members of this type of product may incur higher out-of-pocket expenses for covered services received outside the PPO.

**Protected Health Information (PHI):**

Individually identifiable health information transmitted or maintained in any form or medium (including orally, electronically or on paper).

**Primary Care Physician ("PCP"):**

A primary care physician is a physician who is a family or general practitioner, internist or pediatrician. PCPs provide a broad range of routine medical services and refer Members to specialists, facilities, and other Providers as necessary. Each covered family Member who participates in BlueChoice HMO or Blue Choice Option, chooses his or her own PCP from the Network's physicians.

**Specialists:**

Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), or specific procedures (e.g., oral surgery).

**URAC:**

An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care Providers, consumers, and regulators to promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.

**Utilization Management:**

The process of evaluating a proposed hospitalization, service, or procedure and determining whether the hospitalization, service or procedure meets established guidelines and criteria to be covered under a Member's contract.

**Wellness Programs:**

A broad range of employer sponsored facilities and activities designed to promote safety and good health among employees. Its purpose is to reduce the costs of accidents, sickness, absenteeism, lower productivity and health care costs.

# Exhibits



## NOTICE OF POTENTIAL LIABILITY FORM

### NOTICE OF POTENTIAL LIABILITY

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

ID/Contract # \_\_\_\_\_

Group # \_\_\_\_\_ Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_

Based on the information available at this time, \_\_\_\_\_ (Provider or Facility) and have determined that the following will not be reimbursed by Anthem under the Member's Membership Agreement.

\_\_\_\_\_ Inpatient Admission for \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Additional Inpatient Treatment after \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Other Hospital or Outpatient services \_\_\_\_/\_\_\_\_/\_\_\_\_

Estimated cost of services: \_\_\_\_\_

Expenses incurred for the above treatment(s) will be the responsibility of the Member/patient.

Should the Member or attending physician disagree with this decision, the Member or the attending physician should refer the matter to the Utilization Management Division of Anthem.

#### ACKNOWLEDGEMENTS:

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Hospital Representative Signature

\_\_\_\_\_  
Member Printed Name

\_\_\_\_\_  
Hospital Representative Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hospital Representative Title

\_\_\_\_\_  
Date



Georgia Local Precertification/Prior Authorization List

Updated: April 1, 2023

Certain items and/or criteria referenced in this document applies to local fully-insured Anthem Blue Cross and Blue Shield (Anthem) members in Georgia and select members who are covered under self-insured (ASO) benefit plans with services medically managed as part of a purchased program. It does not apply to BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, or Federal Employee Program® (FEP®) members. The provider will be notified upon requesting precertification if precertification is required for the member. If the program has not been purchased, precertification is not required and will not be performed for the member. For more information, please contact the phone number of the back of the member ID card.

**Eligibility and benefits:**  
Eligibility and benefits can be verified by accessing the Anthem website or by calling the number on the back of the member’s ID card. Service preapproval is based on a member’s benefit plan/eligibility at the time the service is reviewed/approved. Benefit plans vary widely and are subject to change based on the contract implementation dates. The provider is responsible for verification of member eligibility and covered benefits. Except in the case of an emergency, failure to obtain preapproval prior to rendering the designated services listed below will result in denial of reimbursement.

**Carelon Medical Benefits Management, Inc.\***  
Carelon Medical Benefits Management, a separate company, is a nationally recognized leader delivering specialty benefits management on behalf of Georgia for certain health plan members. Determine if preapproval is needed for a Georgia member by clicking the *Medical Policy, Clinical UM Guidelines, and Preapproval Requirements* link on our provider website or by calling the preapproval phone number printed on the back of the member’s ID card. To submit your request for any of the services below, contact Carelon Medical Benefits Management online at [www.providerportal.com](http://www.providerportal.com). From the drop-down menu, select GA. You may also call Carelon Medical Benefits Management toll-free at **866-714-1103**, Monday to Friday, 8 a.m. to 6 p.m. ET.

Carelon Medical Benefit Management provides benefits management for the programs listed below:

- > Cancer Care Quality Program
- > Cardiovascular Services
- > Diagnostic Imaging Management
- > Genetic Testing
- > Imaging Level of Care
- > Musculoskeletal (MSK) Program
- > Oncology Drugs
- > Outpatient Sleep Testing and Therapy Services
- > Rehabilitative Services
- > Radiation Therapy Services
- > Sleep Therapy
- > Upper Gastrointestinal Endoscopy in Adults, and Site of Care for Certain Surgical Services

For more details on these programs, please visit the Carelon Medical Benefits Management website at [www.providerportal.com](http://www.providerportal.com). By visiting this link, you will be linked to websites created and/or maintained by another, separate entity (“External Site”). Upon linking you are subject to the terms of use, privacy, copyright, and security policies of the External Sites. We provide these links solely for your information and convenience. We encourage you to review the privacy practices of the External Sites.

\* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan.

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Reviewed by Carelon Medical Benefits Management:

Code	Code description	Responsible party	Criteria/Guideline	Comments
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	

Code	Code description	Responsible party	Criteria/Guideline	Comments
19296	Placement of radiotherapy afterloading expandable, Catheter (single or multichannel) into the breast for interstitial rad	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
19297	Placement of radiotherapy afterloading expandable, Catheter (single or multichannel) into the breast for interstitial rad	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging, Guidance	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (a	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
20561	Needle insertion(s) without injection(s); 3 or more muscles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, CG-SURG-45, CG-SURG-65	
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20932	Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20933	Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20934	Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separat	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22206	Osteotomy of spine, posterior or posterolateral approach, three, Columns, one vertebral segment (eg, pedicle/vertebral bo	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22207	Osteotomy of spine, posterior or posterolateral approach, three, Columns, one vertebral segment (eg, pedicle/vertebral bo	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	



Code	Code description	Responsible party	Criteria/Guideline	Comments
22208	Osteotomy of spine, posterior or posterolateral approach, three, Columns, one vertebral segment (eg, pedicle/vertebral bo	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22216	Osteotomy, Spine, Posterior/Posterolateral Approach, 1 Vertebral Segment; Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompr	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompr	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompr	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22548	Arthrodesis, Anterior Transoral/Extraoral, Atlas-Axis, W/Wo Excision Odontoid Process	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22554	Arthrodesis, Anterior Interbody, W/Mininmal Diskectomy; Cervical Below C2	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22556	Arthrodesis, Anterior Interbody, W/Mininmal Diskectomy; Thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22558	Arthrodesis, Anterior Interbody, W/Mininmal Diskectomy; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22585	Arthrodesis, Anterior Interbody, W/Mininmal Diskectomy; Add'l Interspace	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22590	Arthrodesis, Posterior Technique, Craniocervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22595	Arthrodesis, Posterior Technique, Atlas-Axis	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22600	Arthrodesis, Posterior/Posterolateral Technique, Single Level; Cervical Below C2	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	



Code	Code description	Responsible party	Criteria/Guideline	Comments
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22614	Arthrodesis, Posterior/Posterolateral Technique, Single Level; Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22630	Arthrodesis, Post Interbody W/Laminectomy &/Or Discect, Prep Interspace, Single Interspace; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22632	Arthrodesis, Post Interbody W/Laminect &/Or Discect, Prep Interspace, Sngl Intrspc; Add'l Interspc	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspa	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22800	Arthrodesis, Posterior, Spinal Deformity, W/Wo Cast; Up To 6 Vertebral Segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22802	Arthrodesis, Posterior, Spinal Deformity, W/Wo Cast; 7 To 12 Vertebral Segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22804	Arthrodesis, Posterior, Spinal Deformity, W/Wo Cast; 13+ Vertebral Segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22808	Arthrodesis, Anterior, Spinal Deformity, W/Wo Cast; 2 To 3 Vertebral Segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22810	Arthrodesis, Anterior, Spinal Deformity, W/Wo Cast; 4 To 7 Vertebral Segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22812	Spinal Fixation, Wiring, Spinous Processes	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22818	Kyphectomy, Exposure Of Spine & Resection Vertebral Segments; 1-2 Segs	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22819	Kyphectomy, Exposure Of Spine & Resection Vertebral Segments; 3 / More	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22830	Exploration of Spinal Fusion	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoax	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 v	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or mo	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	

Code	Code description	Responsible party	Criteria/Guideline	Comments
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than, Sacrum (List separate	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22849	Reinsertion, Spinal Fixation Device	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in, Conjunction with interbody arthrodesis, each inter	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition t	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, CG-SURG-60	
22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervi	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumba	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
23105	Arthrotomy; Glenohumeral Joint, W/Synovectomy, W/Wo Bx	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23107	Arthrotomy, Glenohumeral Joint, W/Exploration, W/Wo Loose/Fb Removal	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23120	Claviculectomy; Partial	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23130	Acromioplasty/Acromionectomy, Partial, W/Wo Coracoacromial Ligament Release	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23410	Repair, Ruptured Musculotendinous Cuff, Open; Acute	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23412	Repair, Ruptured Musculotendinous Cuff; Chronic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	

Code	Code description	Responsible party	Criteria/Guideline	Comments
23415	Coracoacromial Ligament Release, W/Wo Acromioplasty	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23420	Reconstruction, Complete Shoulder (Rotator) Cuff Avulsion, Chronic (Includes Acromioplasty)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23430	Tenodesis, Long Tendon, Biceps	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23440	Resection/Transplantation, Long Tendon, Biceps	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23450	Capsulorrhaphy, Anterior; Putti-Platt Proc/Magnuson Type Operation	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23455	Capsulorrhaphy, Anterior; W/Labral Repair	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23460	Capsulorrhaphy, Anterior, Any Type; W/Bone Block	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23462	Capsulorrhaphy, Anterior, Any Type; W/Coracoid Process Transfer	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23465	Capsulorrhaphy, Glenohumeral Joint, Posterior, W/Wo Bone Block	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23466	Capsulorrhaphy, Glenohumeral Joint, Any Type Multi-Directional Instability	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23470	Arthroplasty, Glenohumeral Joint; Hemiarthroplasty	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23472	Arthroplasty, Glenohumeral Joint; Total Shoulder	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
23700	Manipulation W/Anesthesia, Shoulder Joint, W/Application Of Fixation Apparatus (Excl Dislocation)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
27120	Acetabuloplasty	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27122	Acetabuloplasty; Resection, Femoral Head	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27125	Hemiarthroplasty, Hip, Partial	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27130	Arthroplasty, Acetabular/Proximal Femoral Prosthetic Replacement, W/Wo Autograft/Allograft	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-53	
27132	Conversion, Previous Hip Surgery To Total Hip Arthroplasty, W/Wo Autograft/Allograft	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-53	
27134	Revision, Total Hip Arthroplasty; Both Components, W/Wo Autograft/Allograft	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-53	
27137	Revision, Total Hip Arthroplasty; Acetabular Component Only, W/Wo Autograft/Allograft	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-53	
27138	Revision, Total Hip Arthroplasty; Femoral Component Only, W/Wo Allograft	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-53	
27279	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27331	Arthrotomy, Knee; W/Joint Exploration, Bx/Removal, Loose/Fb	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27332	Arthrotomy, W/Excision, Semilunar Cartilage (Meniscectomy) Knee; Medial/Lateral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27333	Arthrotomy, W/Excision, Semilunar Cartilage (Meniscectomy) Knee; Medial & Lateral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27334	Arthrotomy, W/Synovectomy Knee; Anterior/Posterior	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	

Code	Code description	Responsible party	Criteria/Guideline	Comments
27335	Arthrotomy, W/Synovectomy Knee; Anterior & Posterior W/Popliteal Area	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27403	Arthrotomy W/Meniscus Repair, Knee	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27405	Repair, Primary, Torn Ligament &/Or Capsule, Knee; Collateral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27407	Repair, Primary, Torn Ligament &/Or Capsule, Knee; Cruciate	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27409	Repair, Primary, Torn Ligament &/Or Capsule, Knee; Collateral & Cruciate Ligaments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27412	Autologous Chondrocyte Implantation, Knee	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
27415	Osteochondral allograft, knee, open	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft(s))	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
27425	Lateral Retinacular Release Open	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27427	Ligamentous Reconstruction (Augmentation), Knee; Extra-Articular	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27428	Ligamentous Reconstruction (Augmentation), Knee; Intra-Articular, (Open)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27429	Ligamentous Reconstruction (Augmentation), Knee; Intra-Articular, (Open) & Extra-Articular	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27437	Arthroplasty, Patella; W/O Prosthesis	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27438	Arthroplasty, Patella; W/Prosthesis	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27440	Arthroplasty, Knee, Tibial Plateau	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27441	Arthroplasty, Knee, Tibial Plateau; W/Debridement & Partial Synovectomy	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27442	Arthroplasty, Femoral Condyles/Tibial Plateau(S), Knee	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27443	Arthroplasty, Femoral Condyles/Tibial Plateau(S), Knee; W/Debridement & Partial Synovectomy	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27445	Arthroplasty, Knee, Hinge Prosthesis	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-54	
27446	Arthroplasty, Knee, Condyle & Plateau; Medial/Lateral Compartment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27447	Arthroplasty, Knee, Condyle & Plateau; Medial & Lateral Compartments, W/Wo Patella Resurfacing	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-54	
27486	Revision, Total Knee Arthroplasty, W/Wo Allograft; 1 Component	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-54	
27487	Revision, Total Knee Arthroplasty; Femoral & Entire Tibial Component	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-54	
27488	Removal, Knee Prosthesis, Methylmethacrylate W/Wo Spacer Insertion	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27570	Manipulation, Knee Joint Under General Anesthesia	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
27702	Arthroplasty, Ankle; W/Implant (Total Ankle)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
27703	Arthroplasty, Ankle; Revision, Total Ankle	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
27704	Removal, Ankle Implant	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
27870	Arthrodesis, Ankle, Open	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28110	Ostectomy, Partial Excision, 5th Metatarsal Head (Bunionette) (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28285	Correction, Hammertoe	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28286	Correction, Cock-Up Fifth Toe, W/Plastic Skin Closure	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint with implant	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	



Code	Code description	Responsible party	Criteria/Guideline	Comments
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28295	Correction, hallux valgus (bunion), with or without sesamoidectomy;with proximal metatarsal osteotomy, any method	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28297	Correction, hallux valgus (bunion), with or without sesamoidectomy; Lapidus-type procedure	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28306	Osteotomy, Metatarsal, W/Wo Lengthening/Shortening/Ang Correction; 1st Metatarsal	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28307	Osteotomy, Metatarsal, W/Wo Lengthening/Shortening/Ang Correction; 1st Metatarsal W/Autograft	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28308	Osteotomy, Metatarsal, W/Wo Lengthening/Shortening/Ang Correction; Not 1st Metatarsal, Each	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28310	Osteotomy, Shortening, Angular/Rotational Correction; Proximal Phalanx, 1st Toe (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28312	Osteotomy, Shortening, Angular/Rotational Correction; Other Phalanges, Any Toe	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28315	Sesamoidectomy, 1st Toe (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
28446	Open osteochondral autograft, talus (includes obtaining, Grafts)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
28750	Arthrodesis, Great Toe; Metatarsophalangeal Joint	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Small Joint	
29805	Arthroscopy, Shoulder, Dx, W/Wo Synovial Bx (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29806	Arthroscopy, Shoulder, Surgical; Capsulorrhaphy	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29807	Arthroscopy, Shoulder, Surgical; Repair, Slap Lesion	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29819	Arthroscopy, Shoulder, Surgical; W/Removal, Loose/Fb	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29820	Arthroscopy, Shoulder, Surgical; Synovectomy, Partial	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29821	Arthroscopy, Shoulder, Surgical; Synovectomy, Complete	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29822	Arthroscopy, Shoulder, Surgical; Debridement, Limited	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29823	Arthroscopy, Shoulder, Surgical; Debridement, Extensive	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29824	Arthroscopy, Shoulder, Surgical; Distal Claviclectomy W/ Articular Surface	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29825	Arthroscopy, Shoulder, Surgical; W/Lysis & Resection, Adhesions, W/Wo Manipulation	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	

Code	Code description	Responsible party	Criteria/Guideline	Comments
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29827	Arthroscopy, Shoulder, Surgical; W/Rotator Cuff Repair	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29860	Arthroscopy, Hip, Dx W/Wo Synovial Bx (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29861	Arthroscopy, Hip, Surgical; W/Removal, Loose/Foreign Body	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29862	Arthroscopy, Hip, Surgical; W/Chondroplasty/Arthroplasty, &/Or Resection, Labrum	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29863	Arthroscopy, Hip, Surgical; W/Synovectomy	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
29867	Arthroscopy, Knee, Surgical; Osteochondral Allograft (Eg, Mosaicplasty)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
29868	Arthroscopy, Knee, Surgical; Meniscal Transplantation (Includes Arthrotomy For Meniscal Insertion), Medial Or Lateral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-69	
29870	Arthroscopy, Knee, Dx, W/Wo Synovial Bx (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29871	Arthroscopy, Knee, Surgical; Infection, Lavage & Drainage	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29873	Arthroscopy, Knee, Surgical; W/Lateral Release	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29874	Arthroscopy, Knee, Surgical; Removal, Loose/Fb	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29875	Arthroscopy, Knee, Surgical; Synovectomy, Limited (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more, Compartments (eg, medial or lateral)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29877	Arthroscopy, Knee, Surgical; Debridement/Shaving, Articular Cartilage (Chondroplasty)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29879	Arthroscopy, Knee, Surgical; Abrasion Arthroplasty (W/Chondroplasty)/Multiple Drilling/Microfx	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate, Compartment(s), when performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate, Compartment(s), when performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29882	Arthroscopy, Knee, Surgical; W/Meniscus Repair, Medial/Lateral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29883	Arthroscopy, Knee, Surgical; W/Meniscus Repair, Medial & Lateral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29884	Arthroscopy, Knee, Surgical; W/Lysis, Adhesions, W/Wo Manipulation (Sep Proc)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	

Code	Code description	Responsible party	Criteria/Guideline	Comments
29885	Arthroscopy, Knee, Surgical; Drill, Osteochondritis Dissecans W/Bone Graft, W/Wo Int/Ext Fixation	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29886	Arthroscopy, Knee, Surgical; Drilling, Intact Osteochondritis Dissecans Lesion	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29887	Arthroscopy, Knee, Surgical; Drilling, Intact Osteochondritis Dissecans Lesion W/Int Fixation	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29888	Arthroscopically Aided Anterior Cruciate Ligament Repair/Augmentation/Reconstruction	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29889	Arthroscopically Aided Posterior Cruciate Ligament Repair/Augmentation/Reconstruction	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
29892	Arthroscopically Aided Repair, Osteochondritis/Talar Dome Fx/Tibial Plafond Fx	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-68	
29915	Arthroscopy, subtalar joint, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-68	
29916	Arthroscopy, subtalar joint, surgical; with labral repair	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-68	
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intr	Carelon Medical Benefits Management	Carelon Medical Benefits Management Radiation Therapy	
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire, Course of treatment	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transn	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent stru	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI	
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgical	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI	
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection, Sclerosis of esophageal/gastric varices	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	

Code	Code description	Responsible party	Criteria/Guideline	Comments
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI	
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
47999	Unlisted Proc, Biliary Tract	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
55860	Exposure, Prostate, Any Approach, Radiation Insertion	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
55862	Exposure, Prostate, Any Approach, Radiation Insertion; W/Lymph Node Bx (Limited Pelvic Lymphadenect)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
55865	Exposure, Prostate, Any Approach, Radiation Insertion; W/Bilat Pelvic Lymphadenectomy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
55920	Placement of needles or catheters into pelvic organs and/or genitalia (expect prostate) for subsequent interstitial radi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	



Code	Code description	Responsible party	Criteria/Guideline	Comments
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
58346	Insertion, Heyman, Capsules, Clinical Brachytherapy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple, Cranial lesion	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (Lis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (Li	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary pro	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thora	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thora	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
63001	Laminectomy, W/O Facetectomy/Foraminotomy/Disectomy, 1/2 Segments; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63003	Laminectomy, W/O Facetectomy/Foraminotomy/Disectomy, 1/2 Segments; Thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63005	Laminectomy W/O Facetectomy/Foraminotomy/Disectomy, 1/2 Segments; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63012	Laminectomy W/Removal, Abnormal Facets, Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63015	Laminectomy W/O Facetectomy/Foraminotomy/Disectomy, > 2 Segments; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, CG-SURG-97	
63016	Laminectomy W/O Facetectomy/Foraminotomy/Disectomy, > 2 Segments; Thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	

Code	Code description	Responsible party	Criteria/Guideline	Comments
63017	Laminectomy W/O Facetectomy/Foraminotomy/Diskectomy, > 2 Segments; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63040	Laminotomy W/Partl Facetectmy/Foramnotmy/Herniated Diskect, Re-Exploratn, Sngle Interspc; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63042	Laminotomy W/Partl Facetectomy/Foraminotomy/Herniated Diskect, Re-Explor, Sngle Interspc; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or ex	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or ex	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63045	Laminectomy, Facetectomy & Foraminotomy, 1 Segment; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63046	Laminectomy, Facetectomy & Foraminotomy, 1 Segment; Thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63047	Laminectomy. Facetectomy & Foraminotomy, 1 Segment; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63048	Laminectomy, Facetectomy & Foraminotomy; Add'l Segment, Cervical/Thoracic/Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63050	Laminoplasty, Cervical, With Decompression Of The Spinal Cord, Two Or More Vertebral Segments;	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63051	Laminoplasty, Cerv, W Decompression Of Spinal Cord, 2 Or > Verteb Segments; W Reconstruction Of Posterior Bony Elements	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63055	Transpedicular Approach, 1 Segment; Thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63056	Transpedicular Approach, 1 Segment; Lumbar (Transfacet/Lateral Extraforaminal)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63057	Transpedicular Approach, Add'l Segment; Thoracic/Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63075	Diskectomy, Anterior; Cervical, 1 Interspace	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63076	Diskectomy, Anterior; Cervical, Add'l Interspace	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63081	Vertebral Corpectomy, Anterior; Cervical, 1 Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63082	Vertebral Corpectomy, Anterior; Cervical, Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63085	Vertebral Corpectomy, Transthoracic; Thoracic, 1 Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63086	Vertebral Corpectomy, Transthoracic; Thoracic, Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	

Code	Code description	Responsible party	Criteria/Guideline	Comments
63087	Vertebral Corpectomy, Thoracolumbar, Lower Thoracic/Lumbar; 1 Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63088	Vertebral Corpectomy, Thoracolumbar, Lower Thoracic/Lumbar; Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63090	Vertebral Corpectomy, Transperitoneal/Retroperitoneal, Lower Thoracic/Lumbar/Sacral; 1 Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63091	Vertebral Corpectomy, Trans/Retroperitoneal, Lower Thoracic/Lumbar/Sacral; Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63101	Vertebral Corpectomy, Lateral Extracavitary Approach w Decompression of Spinal Cord/Nerve Roots; Thoracic, Sgl Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63102	Vertebral Corpectomy, Lateral Extracavitary Approach w Decompression of Spinal Cord/Nerve Roots; Lumbar, Sgl Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63103	Vertebral Corpectomy, Lateral Extracavitary Approach w Decompression, Spinal Cord/Nerve Rts; Thoracic/Lumbar, ea addl Seg	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63180	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; 1 or 2 segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63182	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than 2 segments	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63191	Laminectomy W/Section, Spinal Accessory Nerve	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63194	Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63196	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63198	Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63200	Laminectomy, W/Release, Tethered Spinal Cord, Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63250	Laminectomy, Excision/Occlusion, Avm, Spinal Cord; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63252	Laminectomy, Excision/Occlusion, Avm, Spinal Cord; Thoracolumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63265	Laminectomy, Excision, Non-Neoplastic Lesion, Extradural; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63267	Laminectomy, Excision, Non-Neoplastic Lesion, Extradural; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63270	Laminectomy, Excision, Intraspinal Lesion Other Than Neoplasm, Intradural; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63272	Laminectomy, Excision, Intraspinal Lesion Other Than Neoplasm, Intradural; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63275	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Extradural, Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63277	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Extradural, Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63280	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Intradural, Extramedullary, Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63282	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Intradural, Extramedullary, Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63285	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Intradural, Intramedullary, Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63287	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Intradural, Intramedullary, Thoracolumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	

Code	Code description	Responsible party	Criteria/Guideline	Comments
63290	Laminectomy, Bx/Excision, Intraspinal Neoplasm; Extradural-Intradural Lesion, Any Level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63300	Vertebral Corpectomy, 1 Segment; Extradural, Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63301	Vertebral Corpectomy, 1 Segment; Extradural, Thoracic, Transthoracic Approach	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63302	Vertebral Corpectomy, 1 Segment; Extradural, Thoracic, Thoracolumbar Approach	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63303	Vertebral Corpectomy, 1 Segment; Extradural, Lumbar/Sacral, Transperitoneal/Retroperitoneal Approach	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63304	Vertebral Corpectomy, 1 Segment; Intradural, Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63305	Vertebral Corpectomy, 1 Segment; Intradural, Thoracic, Transthoracic Approach	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63306	Vertebral Corpectomy, 1 Segment; Intradural, Thoracic, Thoracolumbar Approach	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63307	Vertebral Corpectomy, 1 Segment; Intradural, Lumbar/Sacral, Transperitoneal/Retroperitoneal Approach	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63308	Vertebral Corpectomy, Add'l Segment	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separat	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
63650	Percutaneous Implantation, Neurostimulator Electrode Array, Epidural	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain, CG-SURG-66	
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including flu	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotom	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
63685	Incision/Placement, Spinal Neurostimulator Pulse Generator/Receiver	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain, CG-SURG-66	
63688	Revision/Removal, Implanted Spinal Neurostimulator Pulse Generator/Receiver	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging, Guidance (fluoroscopy or CT); cervical or thoracic, single level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging, Guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging, Guidance (fluoroscopy or CT); lumbar or sacral, single level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging, Guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	

Code	Code description	Responsible party	Criteria/Guideline	Comments
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary proced	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to co	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code f	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK:	
64633	Destruction By Neurolytic Agent, Paravertebral Facet Joint Nerve(S), With Imaging, Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic, Single Facet Joint	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging, Guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64635	Destruction By Neurolytic Agent, Paravertebral Facet Joint Nerve(S), With Imaging, Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral, Single Facet Joint	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging, Guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
67218	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; radiation by implantation of	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
70336	Mri, Temporomandibular Joints	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70450	Ct Scan, Head/Brain; W/O Contrast Matl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70460	Ct Scan, Head/Brain; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	



Code	Code description	Responsible party	Criteria/Guideline	Comments
70470	Ct Scan, Head/Brain; W/O Contrast, Then W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70480	Ct Scan, Orbit/Sella/Posterior Fossa/Outer, Middle, Inner Ear; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70481	Ct Scan, Orbit/Sella/Posterior Fossa/ Outer, Middle, Inner Ear; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70482	Ct Scan, Orbit/Sella/Posterior Fossa/ Outer, Middle, Inner Ear; W/O Contrast, Then W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70486	Ct Scan, Maxillofacial Area; W/O Contrast Matl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70487	Ct Scan, Maxillofacial Area; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70488	Ct Scan, Maxillofacial Area; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70490	Ct Scan, Soft Tissue Neck; W/O Contrast Matl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70491	Ct Scan, Soft Tissue Neck; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70492	Ct Scan, Neck Tissue; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast ma	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70544	Mra, Head; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70545	Mra, Head; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70546	Mra, Head; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Sequences	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70547	Mra, Neck; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70548	Mra, Neck; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70549	Mra, Neck; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Sequences	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70551	Mri, Brain; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70552	Mri, Brain; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70553	Mri, Brain; W/O Contrast, Then W/Contrast & Further Sequences	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part m	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofun	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71250	Ct Scan, Thorax; W/O Contrast Matl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71260	Ct Scan, Thorax; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71270	Ct Scan, Thorax; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if perfo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71550	Mri, Chest; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71551	Mri, Chest; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	

Code	Code description	Responsible party	Criteria/Guideline	Comments
71552	Mri, Chest; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Sequences	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
71555	Mra, Chest (Exclude Myocardium), W/Wo Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72125	Ct Scan, Cervical Spine; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72126	Ct Scan, Cervical Spine; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72127	Ct Scan, Cervical Spine; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72128	Ct Scan, Thoracic Spine; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72129	Cat,Thoracic Spine;w/Contrst Materl,18-2	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72130	Ct Scan, Thoracic Spine; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72131	Ct Scan, Lumbar Spine; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72132	Ct Scan, Lumbar Spine; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72133	Ct Scan, Lumbar Spine; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72141	Mri, Cervical Spine; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72142	Mri, Cervical Spine; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72146	Mri, Thoracic Spine; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72147	Mri, Thoracic Spine; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72148	Mri, Lumbar Spine; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72149	Mri, Lumbar Spine; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72156	Mri, Spine W/O Contrast, Then W/Contrast; Cervical	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72157	Mri, Spine W/O Contrast, Then W/Contrast; Thoracic	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72158	Mri, Spine W/O Contrast, Then W/Contrast; Lumbar	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72159	Mra, Spine W/Wo Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and ima	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72192	Ct Scan, Pelvis; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72193	Ct Scan, Pelvis; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72194	Ct Scan, Pelvis; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72195	Mri, Pelvis; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72196	Mri, Pelvis; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72197	Mri, Pelvis; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Sequences	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
72198	Mra, Pelvis, W/Wo Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73200	Ct Scan, Upper Extremity; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73201	Ct Scan, Upper Extremity; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73202	Ct Scan, Upper Extremity; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73218	Mri, Upper Extremity, Other Than Joint; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73219	Mri, Upper Extremity, Other Than Joint; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73220	Mri, Upper Extremity, Other Than Joint; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Sequenc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73221	Mri, Any Joint, Upper Extremity; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73222	Mri, Any Joint, Upper Extremity; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	



Code	Code description	Responsible party	Criteria/Guideline	Comments
73223	Mri, Any Joint Of Upper Extremity; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Sequ	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73225	Mra, Upper Extremity, W/Wo Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73700	Ct Scan, Lower Extremity; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73701	Ct Scan, Lower Extremity; W/Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73702	Ct Scan, Lower Extremity; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73718	Mri, Lower Extremity Other Than Joint; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73719	Mri, Lower Extremity Other Than Joint; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73720	Mri, Lower Extremity, Other Than Joint; W/O Contrast Matl(S), Followed Contrast Matl(S) & Furthr Seq	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73721	Mri, Any Joint, Lower Extremity; W/O Contrast Matl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73722	Mri, Any Joint, Lower Extremity; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73723	Mri, Any Joint, Lower Extremity; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Seq	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
73725	Mra, Lower Extremity, W/Wo Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74150	Ct Scan, Abdomen; W/O Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74160	Computed tomography, abdomen; with contrast material(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74170	Ct Scan, Abdomen; W/O Contrast, Then W/Contrast & Further Sections	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74174	Computed Tomographic Angiography, Abdomen And Pelvis, With Contrast Material(S), Including Noncontrast Images, If Performed, And Image Postprocessing	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and im	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74176	Computed tomography, abdomen and pelvis; without contrast material	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74181	Mri, Abdomen; W/O Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74182	Mri, Abdomen; W/Contrast Matl(S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74183	Mri, Abdomen; W/O Contrast Matl(S) Followed By Contrast Matl(S) & Further Sequences	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74185	Mra, Abdomen, W/Wo Contrast	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	

Code	Code description	Responsible party	Criteria/Guideline	Comments
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single of first gestation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast materi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast materi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D ima	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, inc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast materi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
76390	Mr Spectroscopy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
76391	Magnetic resonance (eg, vibration) elastography	Carelon Medical Benefits Management	Radiology & Cardiology	
76873	Echography, Transrectal; Prostate Volume Study, Brachytherapy Planning	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
76965	Us Guided, Interstitial Radioelement Application	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77014	Computed tomography guidance for placement of radiation therapy fields	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
77295	3-dimensional radiotherapy plan, including dose-volume histograms	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77301	Intensity Modulated Radiotherapy Plan W/Dose Volume Histograms	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	

Code	Code description	Responsible party	Criteria/Guideline	Comments
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77370	Special Medical Radiation Physics Consultation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete, Course of treatment of cranial lesion(s) consist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete, Course of treatment of cranial lesion(s) consist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, en	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, THER-RAD.00012	
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77424	Intraoperative Radiation Treatment Delivery, X-Ray, Single Treatment Session	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77425	Intraoperative Radiation Treatment Delivery, Electrons, Single Treatment Session	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete, Course of treatment consisting of 1 session)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image g	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, THER-RAD.00012	
77469	Intraoperative Radiation Treatment Management	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77520	Proton Treatment Delivery; Simple W/O Compensation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77522	Proton Treatment Delivery; Simple W/Compensation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77523	Proton Treatment Delivery; Intermediate	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77525	Proton Treatment Delivery; Complex	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77761	Intracavitary Radiation, Source Application; Simple	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77762	Intracavitary Radiation, Source Application; Intermediate	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77763	Intracavitary Radiation, Source Application; Complex	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77772	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77778	Interstitial Radioelement Application; Complex	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	

Code	Code description	Responsible party	Criteria/Guideline	Comments
77790	Supervision, Handling, Loading, Radiation, Source	Carelon Medical Benefits Management	Carelon Medical Benefits Management Radiation Therapy	
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability):	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation, Correction, qualitative or quantitative wall mo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation, Correction, qualitative or quantitative wall mo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78453	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation, Correction, qualitative or quantitative wall mo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78454	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation, Correction, qualitative or quantitative wall mo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78459	Myocardial Imaging, Positron Emission Tomography (Pet), Metabolic Evaluation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78466	Myocardial Imaging, Infarct Avid, Planar; Qualitative/Quantitative	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78468	Myocardial Imaging, Infarct Avid, Planar; W/Ejection Fraction, 1st Pass Technique	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78469	Myocardial Imaging, Infarct Avid, Planar; Tomographic Spect W/Wo Quantification	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78472	Cardiac Blood Pool Imaging, Gated Equilibrium; Planar, Single Study, Rest/Stress	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78473	Cardiac Blood Pool Imaging, Gated Equilibrium; Planar, Multiple Studies, Rest/Stress	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	



Code	Code description	Responsible party	Criteria/Guideline	Comments
78481	Cardiac Blood Pool Imaging, Planar, 1st Pass; Single Study & Ejection Fraction W/Wo Quantification	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78483	Cardiac Blood Pool Imaging, Planar, 1st Pass; Mult Studies, Rest & Stress & Eject Fractn W/Wo Quant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78491	Myocardial Pet; Single Study, Rest/Stress	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78492	Myocardial Pet; Multiple Studies, Rest &/Or Stress	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78494	Cardiac Blood Pool Imaging, Gated Equilibrium, Rest, Spect, & Ejection Fraction W/Wo Quantification	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78496	Cardiac Blood Pool Imaging, Gated Equilibrium, Single Study, Rest, Rt Vent Ejection Fract, 1st Pass	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78608	Brain Imaging, Positron Emission Tomography (Pet); Metabolic Evaluation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78609	Brain Imaging, Positron Emission Tomography (Pet); Perfusion Evaluation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78800	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (eg, head, neck, chest, pelvis), single day imaging	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation therapy	
78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation therapy	
78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation therapy	
78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation therapy	
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78813	Positron emission tomography (PET) imaging; whole body	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation, Correction and an	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation, Correction and an	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation, Correction and an	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	

Code	Code description	Responsible party	Criteria/Guideline	Comments
79101	Radiopharmaceutical Therapy, By Intravenous Administration	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0112, ING-CC-0118	
79403	Radiopharmaceutical Therapy, Radiolabeled Monoclonal Antibody By Intravenous Infusion	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0118	
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full sequence analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full sequence analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-07	
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81182	ATXN8OS (ATXN8 opposite strand [non-protein, Coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81194	NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81200	Aspa (Aspartoacylase) (Eg, Canavan Disease) Gene Analysis, Common Variants (Eg, E285A, Y231X)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	



Code	Code description	Responsible party	Criteria/Guideline	Comments
81204	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation, Status)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81205	Bckdhhb (Branched-Chain Keto Acid Dehydrogenase E1, Beta Polypeptide) (Eg, Maple Syrup Urine Disease) Gene Analysis, Common Variants (Eg, R183P, G278S, E422X)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81209	Blm (Bloom Syndrome, Recq Helicase-Like) (Eg, Bloom Syndrome) Gene Analysis, 2281Del6Ins7 Variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81210	Braf (V-Raf Murine Sarcoma Viral Oncogene Homolog B1) (Eg, Colon, Cancer), Gene Analysis, V600E Variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-03	
81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; full sequence analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian, Cancer) gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81221	Cftr (Cystic Fibrosis Transmembrane, Conductance Regulator) (Eg, Cystic Fibrosis) Gene Analysis; Known Familial Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81225	Cyp2C19 (Cytochrome P450, Family 2, Subfamily C, Polypeptide 19) (Eg, Drug Metabolism), Gene Analysis, Common Variants (Eg, *2, *3, *4, *8, *17)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81227	Cyp2C9 (Cytochrome P450, Family 2, Subfamily C, Polypeptide 9) (Eg, Drug Metabolism), Gene Analysis, Common Variants (Eg, *2, *3, *5, *6)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00003, CG-GENE-10	
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-10	
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *7)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81241	F5 (Coagulation Factor V) (Eg, Hereditary Hypercoagulability) Gene Analysis, Leiden Variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81242	Fancc (Fanconi Anemia, Complementation Group C) (Eg, Fanconi Anemia, Type, C) Gene Analysis, Common Variant (Eg, lvs4+4A>T)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13, CG-GENE-14	
81243	Fmr1 (Fragile X Mental Retardation 1) (Eg, Fragile X Mental Retardation) Gene Analysis; Evaluation To Detect Abnormal (Eg, Expanded) Alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81244	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81250	G6Pc (Glucose-6-Phosphatase, Catalytic Subunit) (Eg, Glycogen, Storage Disease, Type 1A, Von Gierke Disease) Gene Analysis, Common Variants (Eg, R83C, Q347X)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81251	Gba (Glucosidase, Beta, Acid) (Eg, Gaucher Disease) Gene Analysis, Common Variants (Eg, N370S, 84Gg, L444P, lvs2+1G>A)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81253	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81255	Hexa (Hexosaminidase A [Alpha Polypeptide]) (Eg, Tay-Sachs Disease) Gene Analysis, Common Variants (Eg, 1278Instatc, 1421+1G>C, G269S)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81256	Hfe (Hemochromatosis) (Eg, Hereditary Hemochromatosis) Gene Analysis, Common Variants (Eg, C282Y, H63D)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	

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81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant S	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase, Complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81270	Jak2 (Janus Kinase 2) (Eg, Myeloproliferative Disorder) Gene Analysis, P.Val617Phe (V617F) Variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-01	
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81275	Kras (V-Ki-Ras2 Kirsten Rat Sarcoma Viral Oncogene) (Eg, Carcinoma) Gene Analysis, Variants In, Codons 12 And 13	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-02	
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-02	
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81288	MLH1 (mutL homolog 1, colon, Cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81290	Mcoln1 (Mucolipin 1) (Eg, Mucopolipidosis, Type Iv) Gene Analysis, Common Variants (Eg, lvs3-2A>G, Del6.4Kb)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81292	MLh1 (Mutl Homolog 1, Colon, Cancer, Nonpolyposis Type 2) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Full Sequence Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81293	MLh1 (Mutl Homolog 1, Colon, Cancer, Nonpolyposis Type 2) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Known Familial Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81294	MLh1 (Mutl Homolog 1, Colon, Cancer, Nonpolyposis Type 2) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81295	Msh2 (Muts Homolog 2, Colon, Cancer, Nonpolyposis Type 1) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Full Sequence Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81296	Msh2 (Muts Homolog 2, Colon, Cancer, Nonpolyposis Type 1) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Known Familial Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81297	Msh2 (Muts Homolog 2, Colon, Cancer, Nonpolyposis Type 1) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81298	Msh6 (Muts Homolog 6 [E. Coli]) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Full Sequence Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81299	Msh6 (Muts Homolog 6 [E. Coli]) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Known Familial Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81300	Msh6 (Muts Homolog 6 [E. Coli]) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81302	Mecp2 (Methyl Cpg Binding Protein 2) (Eg, Rett Syndrome) Gene Analysis; Full Sequence Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81303	Mecp2 (Methyl Cpg Binding Protein 2) (Eg, Rett Syndrome) Gene Analysis; Known Familial Variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81304	Mecp2 (Methyl Cpg Binding Protein 2) (Eg, Rett Syndrome) Gene Analysis; Duplication/Deletion Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal and breast cancer) gene analysis, targeted sequence analysis (eg, exons 7, 9,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-12	
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-02	
81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81317	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Full Sequence Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81318	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Known Familial Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81319	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg, Hereditary Non-Polyposis Colorectal Cancer, Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00028	
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden, Syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-08	
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden, Syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-08	
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden, Syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-08	
81330	Smpd1(Sphingomyelin Phosphodiesterase 1, Acid Lysosomal) (Eg, Niemann-Pick Disease, Type A) Gene Analysis, Common Variants (Eg, R496L, L302P, Fsp330)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81331	Snrpn/Ube3A (Small Nuclear Ribonucleoprotein Polypeptide N And Ubiquitin Protein Ligase E3A) (Eg, Prader-Willi Syndrome And/Or Angelman, Syndrome), Methylation Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81333	TGFBI (transforming, Growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	



Code	Code description	Responsible party	Criteria/Guideline	Comments
81350	Ugt1A1 (Udp Glucuronosyltransferase 1 Family, Polypeptide A1) (Eg, Irinotecan Metabolism), Gene Analysis, Common Variants (Eg, *28, *36, *37)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-18	
81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-18	
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-18	
81355	Vkorc1 (Vitamin K Epoxide Reductase, Complex, Subunit 1) (Eg, Warfarin Metabolism), Gene Analysis, Common Variants (Eg, -1639/3673)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81361	HBB (hemoglobin, subunit beta) (eg, sickle, Cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81362	HBB (hemoglobin, subunit beta) (eg, sickle, Cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81363	HBB (hemoglobin, subunit beta) (eg, sickle, Cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81364	HBB (hemoglobin, subunit beta) (eg, sickle, Cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81381	Hla Class I Typing, High Resolution (Ie, Alleles Or Allele Groups); One Allele Or Allele Group (Eg, B*57:01P), Each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
81402	MOLECULAR PATHOLOGY PROCEDURE LEVEL 3	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81408	MOLECULAR PATHOLOGY PROCEDURE LEVEL 9	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00007, GENE.00017, GENE.00037, CG-GENE-13	
81414	Cardiac ion, Channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MY	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping, Genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tiss	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
81545	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP]) Envisia® Genomic Classifier, Veracyte, Inc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00057	
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-06	
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qu	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab; MED.00125	
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab; MED.00125	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	



Code	Code description	Responsible party	Criteria/Guideline	Comments
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language, Comprehension and expression (eg, receptive and expressive language)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92524	Behavioral and qualitative analysis of voice and resonance	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92526	Treatment, Swallowing Dysfunction &/Or Oral Function, Feeding	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92605	Evaluation for prescription of non-speech-generating augmentative and alternative, Communication device, face-to-face with the patient; first hour	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92606	Therapeutic Service(S), Use Non-Speech Generatiing Device, W/Programming & Modification	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92607	Eval, Prescription, Speech-Generating Augmentative & Alternative, Communication Device; 1st Hr	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92608	Eval, Prescrip, Speech-Generating Augmentative & Alternative, Communication Device; Ea Add'l 30 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92609	Therapeutic Services, Non-Speech Generative Device Use, W/Programming & Modification	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92610	Eval, Oral & Pharyngeal Swallow Function	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92611	Motion Fluoroscopic Eval, Swallow Function, Cine/Video Record	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92618	Evaluation for prescription of non-speech-generating augmentative and alternative, Communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
92626	Evaluation of auditory rehabilitation, Status; first hour	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92627	Evaluation of auditory rehabilitation, Status; each additional 15 minutes (List separately in addition to code for primar	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92630	Auditory rehabilitation; pre-lingual hearing loss	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92633	Auditory rehabilitation; post-lingual hearing loss	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	

Code	Code description	Responsible party	Criteria/Guideline	Comments
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vesse	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93303	Transthoracic Echocardiography, Congenital Cardiac Anomalies; Complete	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93304	Transthoracic Echocardiography, Congenital Cardiac Anomalies; Follow-Up/Limited Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acq	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93315	Echocardiography, Transesophageal, Congenital Anomalies; W/Probe, Image, Intepretation & Report	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93316	Echocardiography, Transesophageal, Congenital Anomalies; Transesophageal Probe Placement Only	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93317	Echocardiography, Transesophageal, Congenital Anomalies; Image, Interpretation & Report	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93320	Doppler Echocardiography; Complete	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93321	Doppler Echocardiography; Follow-Up/Limited	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93325	Doppler Color Flow Mapping	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, dur	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	

Code	Code description	Responsible party	Criteria/Guideline	Comments
93454	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93455	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, ven	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93456	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93457	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, ven	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93458	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93459	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93460	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93461	Catheter placement in, Coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93880	Duplex Scan, Extracranial Arteries; Complete Bilat Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93882	Duplex Scan, Extracranial Arteries; Unilat/Limited Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	

Code	Code description	Responsible party	Criteria/Guideline	Comments
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93925	Duplex Scan, Lower Extremity Arteries/Arterial Bypass Grafts; Complete Bilat Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93926	Duplex Scan, Lower Extremity Arteries/Arterial Bypass Grafts; Unilat/Limited Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93930	Duplex Scan, Upper Extremity Arteries/Arterial Bypass Grafts; Complete Bilat Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93931	Duplex Scan, Upper Extremity Arteries/Arterial Bypass Grafts; Unilat/Limited Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93978	Duplex Scan, Aorta, Inferior Vena Cava, Iliac Vasculature/Bypass Grafts; Complete Study	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93979	Duplex Scan, Aorta, Inferior Vena Cava, Iliac Vasculature/Bypass Grafts; Unilat/Limited	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
94667	Chest Wall Manipulation, Facilitate Lung Function; Initial Demo &/Or Eval	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
94668	Chest Wall Manipulation, Facilitate Lung Function; Subsequent	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen, Saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen, Saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95805	Multiple Sleep Latency Test, Multiple Trails	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen, Saturation, respiratory airflow, and respiratory	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95807	Sleep Study, Attended	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	

Code	Code description	Responsible party	Criteria/Guideline	Comments
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
96001	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measuremen	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
97010	Application of a modality to 1 or more areas; hot or cold packs	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97012	Application of a modality to 1 or more areas; traction, mechanical	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
97016	Application of a modality to 1 or more areas; vasopneumatic devices	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97018	Application of a modality to 1 or more areas; paraffin bath	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97022	Application of a modality to 1 or more areas; whirlpool	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97026	Application of a modality to 1 or more areas; infrared	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97028	Application of a modality to 1 or more areas; ultraviolet	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97032	Application, Modality 1+ Areas; Electrical Stimulation (Manual), Each 15 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97034	Application, Modality To 1+ Areas; Contrast Baths, Each 15 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97035	Application, Modality To 1+ Areas; Ultrasound, Each 15 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97036	Application, Modality To 1+ Areas; Hubbard Tank, Each 15 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97110	Therapeutic Proc, 1+ Areas, Each 15 Min; Therapeutic Exercises	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97112	Therapeutic Proc, 1+ Areas, Each 15 Min; Neuromuscular Reeducation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97113	Therapeutic Proc, 1+ Areas, Each 15 Min; Aquatic Therapy W/Exercises	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97116	Therapeutic Proc, 1+ Areas, Each 15 Min; Gait Training (W/Stair Climbing)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97124	Therapeutic Proc, 1+ Areas, Each 15 Min; Massage	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensato	Carelon Medical Benefits Management	Carelon Medical Benefits Management: REHAB	
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensato	Carelon Medical Benefits Management	Carelon Medical Benefits Management: REHAB	
97140	Manual Therapy Techniques, 1+ Regions, Each 15 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	



Code	Code description	Responsible party	Criteria/Guideline	Comments
97150	Therapeutic Proc(S), Group, (2+ Individuals)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97161	Physical therapy evaluation; low complexity, requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97162	Physical therapy evaluation; moderate, Complexity requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97163	Physical therapy evaluation; high complexity requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97164	Reevaluation of physical therapy established plan of care requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97165	Occupational therapy evaluation; low complexity requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
97166	Occupational therapy evaluation; moderate, Complexity requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
97167	Occupational therapy evaluation; high complexity requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
97168	Reevaluation of occupational therapy care/established plan of care requiring components	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Occupational Therapy	
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one, Contact, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one, Cont	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97545	Work Hardening/Conditioning; Initial 2 Hours	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97546	Work Hardening/Conditioning; Add'l Hr	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97750	Physical Performance Test, W/Written Report, Each 15 Min	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one, Contact, with written report, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	

Code	Code description	Responsible party	Criteria/Guideline	Comments
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-01	
0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation, Sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignanc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-01	
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G])	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0045U	Oncology (breast ductal carcinoma in Situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	



Code	Code description	Responsible party	Criteria/Guideline	Comments
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 5' gene duplication/multiplication) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3' gene duplication/multiplication) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00023	
0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (ie, benign, indeterminate, malignant)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00023	
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, CG-SURG-60	
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, CG-SURG-60	
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-02	
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a tripl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0155U	PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (eg, breast cancer) gene analysis (ie, p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-12	
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separ	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspa	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negativ	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00037	
0206U	Neurology (Alzheimer disease); cell aggregation using morphometric imaging and protein kinase C-epsilon (PKCe) concentration in response to amylospheroid treatment by ELISA, c	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0207U	Neurology (Alzheimer disease); quantitative imaging of phosphorylated ERK1 and ERK2 in response to bradykinin treatment by in situ immunofluorescence, using cultured skin fibr	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0208U	Pure tone audiometry (threshold), automated; air only	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-10	
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-05	
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic;	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic;	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; sing	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, del	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic region	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0233U	FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expa	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0234U	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0235U	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence chan	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0237U	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, dupl	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage ThyGeNEXT® Thyroid Oncogene Panel, Interpace Diagnostics, Interpace Diagnostics	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04	
0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and deletions, one amplification, and four translocations), microsatellite instability and tumor-mutation burden PGDx elio™ tissue complete, Personal Genome Diagnostics, Inc, Personal Genome Diagnostics, Inc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation, Software analysis of functional data to assess the severity of coronary artery	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation, Software analysis of functional data to assess the severity of coronary artery	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation, Software analysis of functional data to assess the severity of coronary artery	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation, Software analysis of functional data to assess the severity of coronary artery	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC, CG-MED-59	
0653T	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC, CG-MED-59	
0654T	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC, CG-MED-59	
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intr	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
77790	Supervision, Handling, Loading, Radiation Source	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
A4604	Tubing with integrated heating element for use with positive airway pressure device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7027	Combination oral/nasal mask, used with continuous positive airway pressure	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7030	Full Face Mask Used With Positive Airway Pressure Device, Each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7031	Face Mask Interface, Replacement For Full Face Mask, Each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7032	Cushion for use on nasal mask interface, replacement only, each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7034	Nasal Interface (Mask Or Cannula Type) Used With Positive Airway Press	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	

Code	Code description	Responsible party	Criteria/Guideline	Comments
A7035	Headgear Used With Positive Airway Pressure Device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7036	Chinstrap Used With Positive Airway Pressure Device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7037	Tubing Used With Positive Airway Pressure Device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7038	Filter, Disposable, Used With Positive Airway Pressure Device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7039	Filter, Non Disposable, Used With Positive Airway Pressure Device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7044	Oral Interface Used With Positive Airway Pressure Device, Each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7045	Repl exhalation port for PAP	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
A9590	Iodine I-131, iobenguane, 1 mCi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0118	
C9062	#N/A	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
C9069	Injection, belantamab mafodontin-blmf, 0.5 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
C9070	Injection, tafasitamab-cxix, 2 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
C9083	Injection, amivantamab-vmjw, 10 mg [Rybrevant]	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
E0470	Respiratory assist device, bi-level pressure, Capability, without backup rate	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
E0471	Respiratory assist device, bi-level pressure, Capability, with back-up rate	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, inclu	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
E0561	Humidifier, non-heated, used with positive airway pressure device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
E0562	Humidifier, heated, used with positive airway pressure device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
E0601	Continuous positive airway pressure (cpap) device	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
E0748	Elec Osteogen, Stim Spinal	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
G0260	Injection Procedure For Sacroiliac Joint; Provision Of Anesthetic, Ste	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Pain	
G0281	Electrical Stimulation, (Unattended), To One Or More Areas, For Chroni	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
G0282	Electrical Stimulation, (Unattended), To One Or More Areas, For Wound	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
G0283	Electrical Stimulation (Unattended), To One Or More Areas For Indicati	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
G0289	Arthroscopy, Knee, Surgical, For Removal Of Loose Body, Foreign Body,	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-43	
G0295	Electromagnetic Stimulation, To One Or More Areas	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
G0297	Low dose, Ct scan (Idct) for lung cancer screening	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
G0329	Electromagntic tx for ulcers	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
G0339	Robot lin-radsurg com, first	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G0340	Robt lin-radsurg fractx 2-5	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	



Code	Code description	Responsible party	Criteria/Guideline	Comments
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart r	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment	
G0458	Low dose rate (ldr) prostate brachytherapy services, composite rate	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6001	Ultrasonic guidance for placement of radiation therapy fields	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6003	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: up to 5mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6004	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 6-10mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6005	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 11-19mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6006	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 20mev or greater	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6011	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6012	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6013	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19mev	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6014	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20mev or greater	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	

Code	Code description	Responsible party	Criteria/Guideline	Comments
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
J0207	Amifostine	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0155	
J0641	Injection, levoleucovorin, 0.5 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0104	
J0642	Injection, levoleucovorin (khapzory), 0.5 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0104	
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0074	
J2505	Injection, pegfilgrastim, 6 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
J2820	Sargramostim Injection	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
J2860	Injection, siltuximab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0113	
J7330	Cultured Chondrocytes Implnt	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint	
J9019	Injection, asparaginase (erwinaze), 1,000 iu	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0096	
J9022	Injection, atezolizumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0128	
J9023	Injection, avelumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0129	
J9033	Injection, bendamustine HCl (Treanda), 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0116	
J9034	Injection, bendamustine hcl (bendeka), 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0116	
J9036	Injection, bendamustine hydrochloride, (Belrapzo), 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0116	
J9039	Injection, blinatumomab, 1 microgram	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0126	
J9042	Injection, brentuximab vedotin, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0092	
J9043	Injection, cabazitaxel, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0114	
J9047	Injection, carfilzomib, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0120	
J9055	Cetuximab injection	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0106	
J9057	Injection, copanlisib, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0133	
J9118	Injection, calaspargase pegol-mknl, 10 units	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0096	
J9119	Injection, cemiplimab-rwlc, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0145	
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
J9145	Injection, daratumumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0127	
J9173	Injection, durvalumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0130	
J9176	Injection, elotuzumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0117	
J9179	Injection, eribulin mesylate, 0.1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0108	
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0132	
J9207	Injection, ixabepilone, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0090	
J9216	Injection, interferon, gamma-1B, 3 million units	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0085	
J9223	Injection, lurbinectedin, 0.1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
J9228	Injection, ipilimumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0119	
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0131	
J9264	Injection, paclitaxel protein-bound particles, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0099	
J9266	Injection, pegaspargase, per single dose vial	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0096	
J9269	Injection, tagraxofusp-erzs, 10 micrograms	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0088	
J9271	Injection, pembrolizumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0124	
J9281	Mitomycin pyelocalyceal instillation, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
J9285	Injection, olaratumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0091	
J9299	Injection, nivolumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0125	



Code	Code description	Responsible party	Criteria/Guideline	Comments
J9301	Injection, obinutuzumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0121	
J9302	Injection, ofatumumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0122, ING-CC-0174	
J9303	Injection, panitumumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0105	
J9304	Injection, pemetrexed, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0094	
J9305	Pemetrexed injection	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0094	
J9306	Injection, pertuzumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0110	
J9308	Injection, ramucirumab, 5 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0123	
J9309	Injection, polatuzumab vedotin-piiq, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0157	
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0144	
J9315	Injection, romidepsin, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0100	
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology	
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0135	
J9354	Injection, ado-trastuzumab emtansine, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0115	
J9395	Injection, fulvestrant, 25 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0103	
J9400	Injection, ziv-aflibercept, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0109	
J9999	NOC, antineoplastic drug	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, Radiation Therapy; MED.00085, ING-CC-0036, ING-CC-0075, ING-CC-0138, ING-CC-0167, ING-CC-0186, ING-CC-0187, ING-CC-0191, ING-CC-0201	
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0134	
Q2049	Injection, doxorubicin hydrochloride, liposomal, imported Lipodox, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0098	
Q2050	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0098	
Q3001	Brachytherapy Radioelements	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte, Cells)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, CG-SURG-67	
S3800	Genetic testing for amyotrophic lateral sclerosis (ALS)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3840	DNA analysis for germline mutations of the ret proto-oncogene	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-17	
S3841	Genetic testing for retinoblastoma	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3842	Genetic testing for von hippel-lindau disease	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3844	DNA analysis of the, Connexin 26 gene (gjb2) for susceptibility to congenital, profound deafness	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3845	Genetic testing for alpha-thalassemia	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3846	Genetic testing for hemoglobin e beta-thalassemia	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3849	Genetic testing for niemann-pick disease	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3850	Genetic testing for sickle, Cell anemia	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
S3853	Genetic testing for myotonic muscular dystrophy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3854	Gene expression profiling panel for use in the management of breast cancer treatment	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
S3861	Genetic testing, sodium channel, voltage-gated, Type V, alpha subunit (SCN5A) and variants for suspected brugada syndrom	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	

Code	Code description	Responsible party	Criteria/Guideline	Comments
S3870	Comparative genomic hybridization (cgh) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-BEH-01, CG-GENE-10, CG-GENE-13	
S8092	Electron beam computed tomography (also known as Ultrafast CT, Cine CT)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology	
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00026	
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome) circulating cell-free fetal DNA in maternal blood	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00026	
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81436	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK1	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy	
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, S	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MA	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucopolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, p	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence varian	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00033	
81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequenc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NR	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary op	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81479	Unlisted molecular pathology procedure	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00055, GENE.00052	
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00050	
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00018	
81506	Endocrinology, Biochemical Assays Of Seven Analytes Utilizing Serum Or Plasma, Algorithm Reporting A Risk Score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81507	Fetal aneuploidy (trisomy 21, 18, and 13) dna sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00026	
S8940	EQUESTRIAN/HIPPOTHERAPY PER SESSION	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
S8948	Application of a modality (requiring constant provider attendance) to one or	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
S8950	Complex Lymphedema Therapy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy	
S9090	Vertebral Axial Decompressio	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab	
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00016	
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main, Cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00018	
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk s	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate, Cancer detection on repeat biopsy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed pa	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00023	
81599	Unlisted Multianalyte Assay With Algorithmic Analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-04, CG-GENE-19, GENE.00009, GENE.00016, GENE.00018, GENE.00020, GENE.00023, GENE.00025, GENE.00026, GENE.00037, GENE.00052, GENE.00055, CG-GENE-13, LAB.00016, LAB.00019	
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise sp	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00003	
84999	Unlisted Chemistry Proc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00003, GENE.00016, GENE.00023, LAB.00011, LAB.00019, LAB.00025, LAB.00028, LAB.00030	
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-02, GENE.00025	
90901	Biofeedback Training, Any Modality	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Physical Therapy, MED.00125	



Code	Code description	Responsible party	Criteria/Guideline	Comments
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, com	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, com	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, fol	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiology & Cardiology	
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
0007U	Drug test(s), presumptive, with definitive, Confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in, Comparison to buccal DNA, per date of service	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00041	
0011M	Oncology, prostate, Cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and urine, algorithms to predict high-grade prostate, Cancer risk	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
0012U	Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0013U	Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0014U	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00025	
0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
S9152	Speech therapy, re-evaluation	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraff	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0053U	Oncology (prostate, Cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression, Score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00016	
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positiv	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing	
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms(SNPs), urine and buccal DNA, for specimen identity verification	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00041	
0094U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, <i>PTEN</i> hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to r	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	



Code	Code description	Responsible party	Criteria/Guideline	Comments
0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when ind	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00053	
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
0129U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel <i>(ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN,</i> and	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel <i>(APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN.</i> and <i>TP53)</i> (List	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0131U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0132U	Hereditary ovarian cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0133U	Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054, CG-GENE-13	
0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0138U	<i>BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated)</i> (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0152U	Infectious disease (bacteria, fungi, parasites, and DNA viruses), DNA, PCR and next-generation sequencing, plasma, detection of >1,000 potential microbial organisms for signif	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00053	
V5362	Speech Screening	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
0154U	FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
0157U	APC (APC regulator of WNT signaling pathway) (eg, familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0158U	MLH1 (mutL homolog 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0159U	MSH2 (mutS homolog 2) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0160U	MSH6 (mutS homolog 6) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00054	
0168U	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma without fetal fraction cutoff, algorithm reported as a risk score for	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00026	
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequenc	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homol	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-16	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 gene	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00010	
0177U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-12	
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior kno	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00049	
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continu	Carelon Medical Benefits Management	GENE.00055	
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tand	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tand	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tande	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tande	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and va	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment, DME.00039	
E1399	Durable medical equipment, miscellaneous	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Sleep Testing and Treatment, SURG.00007, CG-ANC-08	
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen, Scaffold, Menaflex)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Joint, SURG.00011	
S3852	DNA analysis for apoe epsilon 4 allele for susceptibility to Alzheimer's disease	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00003;	
V5363	Language Screening	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	

Code	Code description	Responsible party	Criteria/Guideline	Comments
V5364	Dysphagia Screening	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Rehab - Speech Therapy	
Various Codes	Colonoscopy - Screening & Diagnostic	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Ear /Auditory Canal	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures, Anus, Colon and Rectum, Esophagus, Intestines, Lips, Liver, Mouth & Buccal Cavity, adnoids/throat/tonsils, Palate and uvula, salviary ducts and glands, teeth and supporting structures, Abdomen/Peritoneum & Omentum	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Anterior Segment of Ocular, Conjunctiva, Eye Ball, Lacrimal system, Ocular Adnexa, Posterior Segment Ocular	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Cervix Uteri, Cervix Uteri, Vagina, Maternity Care and Delivery, Oviduct/Ovary, Vulva, Perineum, and Introitus	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Hemic and Lymphatic Systems	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of the Breast, Integumentary system (General), Pilonadal cyst, Skin, Subcutaneous, and Accessory Structures	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Male Genital System	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Musculoskeletal system	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Various Codes	Procedures of Accessory sinues, Larynx, Nasal Structure, Trachea and Bronchi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online www.providerportal.com. You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .

Code	Code description	Responsible party	Criteria/Guideline	Comments
Various Codes	Procedures of bladder, kidney, ureter, urethra	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Surgical SOC	Contact Carelon Medical Benefits Management online <a href="http://www.providerportal.com">www.providerportal.com</a> . You may also call Carelon Medical Benefits Management toll-free at <b>866-714-1103</b> .
Reviewed by Anthem:				
Code	Code description	Responsible party	Criteria/Guideline	Comments
00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator	Anthem	CG-SURG-63; CG-SURG-97	
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy	Anthem	CG-SURG-99	
11920	Tattooing To Correct Color Defects; 6.0 Sq Cm/<	Anthem	SURG.00023	
11921	Tattooing To Correct Color Defects; 6.1-20.0 Sq Cm	Anthem	SURG.00023	
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmen	Anthem	SURG.00023	
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Anthem	MED.00132	
11951	Subq Injection, Filling Matl; 1.1 To 5.0 Cc	Anthem	MED.00132	
11952	Subq Injection, Filling Matl; 5.1 To 10.0 Cc	Anthem	MED.00132	
11954	Subq Injection, Filling Matl; > 10.0 Cc	Anthem	MED.00132	
14040	Adjacent Tissue Transfer, Forehead/Cheeks/Chin/Mouth/Neck/Axillae/Genitalia/Hands/Feet; 10 Sq Cm/<	Anthem	SURG.00096	
14041	Adjacent Tissue Transfer, Forehead/Cheeks/Chin/Mouth/Neck/Axillae/Genitalia/Hands/Feet;10.1-30.0sqcm	Anthem	SURG.00096	
14060	Adjacent Tissue Transfer/Rearrangement, Eyelids/Nose/Ears/Lips; Defect 10 Sq Cm/<	Anthem	SURG.00096	
14061	Adjacent Tissue Transfer/Rearrangement, Eyelids/Nose/Ears/Lips; Defect 10.1-30.0 Sq Cm	Anthem	SURG.00096	
15150	Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	Anthem	SURG.00011	
15155	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	Anthem	SURG.00011	
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Anthem	MED.00132	
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in	Anthem	MED.00132	
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Anthem	MED.00132	
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or p	Anthem	MED.00132	
15775	Punch graft for hair transplant; 1 to 15 punch grafts	Anthem	ANC.00007	
15776	Punch graft for hair transplant; more than 15 punch grafts	Anthem	ANC.00007	



Code	Code description	Responsible party	Criteria/Guideline	Comments
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Anthem	ANC.00007	
15781	Dermabrasion; segmental, face	Anthem	ANC.00007	
15782	Dermabrasion; regional, other than face	Anthem	ANC.00007	
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	Anthem	ANC.00007	
15786	Abrasion; single lesion (eg, keratosis, scar)	Anthem	ANC.00007	
15788	Chemical peel, facial; epidermal	Anthem	ANC.00007	
15792	Chemical peel, nonfacial; epidermal	Anthem	ANC.00007	
15793	Chemical peel, nonfacial; dermal	Anthem	ANC.00007	
15820	Blepharoplasty, lower eyelid;	Anthem	CG-SURG-03	
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Anthem	CG-SURG-03	
15822	Blepharoplasty, upper eyelid;	Anthem	CG-SURG-03	
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Anthem	CG-SURG-03	
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Anthem	ANC.00008	
15826	Rhytidectomy; glabellar frown lines	Anthem	ANC.00008; SURG.00096	
15828	Rhytidectomy; cheek, chin, and neck	Anthem	ANC.00008	
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Anthem	ANC.00008	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Anthem	CG-SURG-99	
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Anthem	ANC.00009	
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Anthem	ANC.00009	
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Anthem	ANC.00009	
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Anthem	ANC.00009	
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Anthem	ANC.00009	
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Anthem	ANC.00009	
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Anthem	ANC.00008	
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Anthem	ANC.00009	
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)	Anthem	ANC.00008	
15841	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)	Anthem	ANC.00008	
15842	Graft, Facial Nerve Paralysis; Free Muscle Flap, Microsurgical Technique	Anthem	ANC.00008	
15845	Graft, Facial Nerve Paralysis; Regional Muscle Transfer	Anthem	ANC.00008	
15847	Excision, excessive skin and subcutaneous tissue (including lipectomy), abdomen (eg, abdominoplasty) (includes umbilical	Anthem	CG-SURG-99	
15876	Suction Assisted Lipectomy; Head & Neck	Anthem	ANC.00008, CG-MED-63	
15877	Suction Assisted Lipectomy; Trunk	Anthem	ANC.00009, SURG.00023, CG-SURG-71, SURG.00023, CG-SURG-88, CG-SURG-99	
15878	Suction Assisted Lipectomy; Upper Extremity	Anthem	ANC.00009, CG-MED-63	
15879	Suction Assisted Lipectomy; Lower Extremity	Anthem	ANC.00009, CG-MED-63	
17106	Destruction, Cutaneous Vascular Proliferative Lesions; < 10 Sq Cm	Anthem	ANC.00007	
17107	Destruction, Cutaneous Vascular Proliferative Lesions; 10.0-50.0 Sq Cm	Anthem	ANC.00007	

Code	Code description	Responsible party	Criteria/Guideline	Comments
17108	Destruction, Cutaneous Vascular Proliferative Lesions; > 50.0 Sq Cm	Anthem	ANC.00007	
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, colo	Anthem	CG-SURG-90	
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, colo	Anthem	CG-SURG-90	
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, colo	Anthem	CG-SURG-90	
17380	Electrolysis epilation, each 30 minutes	Anthem	ANC.00007, CG-SURG-27	
17999	Unlisted Proc, Skin, Mucous Membrane & Subq Tissue	Anthem	ANC.00007, CG-SURG-27, CG-SURG-99, ING-CC-0036	
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Anthem	CG-SURG-61	
19303	Mastectomy , simple, complete	Anthem	CG-SURG-27	
19316	Mastopexy	Anthem	SURG.00023	
19318	Reduction Mammoplasty	Anthem	SURG.00023, CG-SURG-27, CG-SURG-71	
19324	Mammoplasty, Augmentation; W/O Prosthetic Implant	Anthem	SURG.00023	
19325	Mammoplasty, Augmentation; W/Prosthetic Implant	Anthem	SURG.00023	
19328	Removal, Intact Mammary Implant	Anthem	SURG.00023	
19330	Removal, Mammary Implant Matl	Anthem	SURG.00023	
19340	Immediate Insertion, Breast Prosthesis Following Mastopexy, Mastectomy/In Reconstruction	Anthem	SURG.00023	
19342	Delayed Insertion, Breast Prosthesis Following Mastopexy, Mastectomy/In Reconstruction	Anthem	SURG.00023	
19350	Nipple/Areola Reconstruction	Anthem	SURG.00023	
19355	Correction, Inverted Nipples	Anthem	SURG.00023	
19357	Breast Reconstruction W/Tissue Expander, Immediate/Delayed, W/Subseq Expansion	Anthem	SURG.00023	
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	Anthem	SURG.00023	
19364	Breast Reconstruction W/Free Flap	Anthem	SURG.00023	
19366	Breast Reconstruction W/Other Technique	Anthem	SURG.00023	
19367	Breast Reconstruction W/Myocutaneous (Tram) Flap, Single Pedicle W/Closure Donor Site;	Anthem	SURG.00023	
19368	Breast Reconstruction W/Myocutan (Tram) Flap, Single Pedicle W/Closure Donor Site; W/Microvasc Anast	Anthem	SURG.00023	
19369	Breast Reconstruction W/Myocutaneous (Tram) Flap, Double Pedicle W/Closure Donor Site	Anthem	SURG.00023	
19370	Open Periprosthetic Capsulotomy, Breast	Anthem	SURG.00023	
19371	Periprosthetic Capsulectomy, Breast	Anthem	SURG.00023	
19380	Revision, Reconstructed Breast	Anthem	SURG.00023	
19396	Preparation, Moulage, Custom Breast Implant	Anthem	SURG.00023	
19499	Unlisted Proc, Breast	Anthem	SURG.00044, SURG.00137	
20975	Electrical Stimulation To Aid Bone Healing; Invasive (Operative)	Anthem	CG-DME-40	
20979	Low Intensity Ultrasound Stimulation To Aid Bone Healing; Noninvasive	Anthem	CG-DME-45	
20982	Ablation, Bone Tumor(s) Radiofrequency, Percutaneous, Including Computed Tomographic Guidance	Anthem	CG-SURG-61	



Code	Code description	Responsible party	Criteria/Guideline	Comments
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Anthem	CG-SURG-61	
20999	Unlisted Proc, Musculoskeletal System, General	Anthem	SURG.00045	
21083	Impression & Custom Preparation; Palatal Lift Prosthesis	Anthem	ANC.00008	
21087	Impression & Custom Preparation; Nasal Prosthesis	Anthem	ANC.00008	
21120	Genioplasty; Augmentation (Autograft, Allograft, Prosthetic Matl)	Anthem	CG-SURG-84	
21121	Genioplasty; Sliding Osteotomy, Single Piece	Anthem	CG-SURG-84	
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin	Anthem	CG-SURG-84	
21123	Genioplasty; Sliding, Augmentation W/Interpositional Bone Grafts W/Obtaining Autograft	Anthem	CG-SURG-84	
21125	Augmentation, Mandibular Body/Angle; Prosthetic Matl	Anthem	CG-SURG-84	
21127	Augmentation, Mandibular Body/Angle; W/Bone Graft/Onlay/Interpositional W/Obtaining Autograft	Anthem	CG-SURG-84	
21137	Reduction Forehead; Contouring Only	Anthem	ANC.00008	
21138	Reduction Forehead; Contouring/Prosthesis/Bone Graft W/Obtaining Autograft	Anthem	ANC.00008	
21139	Reduction Forehead; Contouring & Setback, Anterior Frontal Sinus Wall	Anthem	ANC.00008	
21141	Reconstruction Midface, Lefort I; 1 Piece, W/O Bone Graft	Anthem	CG-SURG-84	
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	Anthem	CG-SURG-84	
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	Anthem	CG-SURG-84	
21145	Reconstruction Midface, Lefort I; 1 Piece, W/Bone Grafts	Anthem	CG-SURG-84	
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining	Anthem	CG-SURG-84	
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes o	Anthem	CG-SURG-84	
21150	Reconstruction Midface, Lefort Ii; Anterior Intrusion	Anthem	CG-SURG-84	
21151	Reconstruction Midface, Lefort Ii; W/Bone Grafts	Anthem	CG-SURG-84	
21154	Reconstruction Midface, Lefort Iii, W/Bone Grafts; W/O Lefort I	Anthem	CG-SURG-84	
21155	Reconstruction Midface, Lefort Iii, W/Bone Grafts; W/Lefort I	Anthem	CG-SURG-84	
21159	Reconstruction Midface, Lefort Iii, (Extra/Intracranial), W/Bone Grafts, W/O Lefort I	Anthem	ANC.00008	
21160	Reconstruction Midface, Lefort Iii, (Extra/Intracranial), W/Bone Grafts, W/Lefort I	Anthem	ANC.00008	

Code	Code description	Responsible party	Criteria/Guideline	Comments
21172	Reconstruction Superior-Lateral Orbital Rim & Lower Forehead	Anthem	ANC.00008	
21175	Reconstruction, Bifrontal,Superior-Lateral Orbital Rims & Lower Forehead	Anthem	ANC.00008	
21179	Reconstruction, Majority, Forehead & Supraorbital Rims; W/Grafts (Allograft/Prosthetic)	Anthem	ANC.00008	
21180	Reconstruction, Majority, Forehead & Supraorbital Rims; W/Autograft	Anthem	ANC.00008	
21188	Reconstruction, Midface, Osteotomies (Non-Lefort Type), W/Grafts, W/Obtaining Autografts	Anthem	CG-SURG-84	
21193	Reconstruction, Mandibular Rami, Horizontal, Vertical, "C"/"L" Osteotomy; W/O Bone Graft	Anthem	SURG.00129, CG-SURG-84	
21194	Reconstruction, Mandibular Rami, Horizontal, Vertical, "C"/"L" Osteotomy; W/Bone Graft	Anthem	SURG.00129, CG-SURG-84	
21195	Reconstruction, Mandibular Rami &/Or Body, Sagittal Split; W/O Int Rigid Fixation	Anthem	SURG.00129, CG-SURG-84	
21196	Reconstruction, Mandibular Rami &/Or Body, Sagittal Split; W/Int Rigid Fixation	Anthem	SURG.00129, CG-SURG-84	
21198	Osteotomy, Mandible, Segmental	Anthem	SURG.00129, CG-SURG-84	
21199	Osteotomy, Mandible, Segmental; W/Genioglossus Advancement	Anthem	SURG.00129, CG-SURG-84	
21206	Osteotomy, Maxilla, Segmental	Anthem	SURG.00129, CG-SURG-84	
21208	Osteoplasty, Facial Bones; Augmentation (Autograft, Allograft/Prosthetic Implant)	Anthem	CG-SURG-84	
21209	Osteoplasty, Facial Bones; Reduction	Anthem	CG-SURG-84	
21210	Graft, Bone; Nasal, Maxillary/Malar Areas (Includes Obtaining Graft)	Anthem	ANC.00008, CG-SURG-84	
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	Anthem	CG-SURG-84	
21230	Graft; Rib Cartilage, Autogenous, Face/Chin/Nose/Ear (Includes Obtaining Graft)	Anthem	ANC.00008	
21235	Graft; Ear Cartilage, Autogenous, Nose/Ear (Includes Obtaining Graft)	Anthem	ANC.00008	
21244	Reconstruction, Mandible, Extraoral, W/Transosteal Bone Plate	Anthem	CG-SURG-84	
21245	Reconstruction, Mandible/Maxilla, Subperiosteal Implant; Partial	Anthem	CG-SURG-84	
21246	Reconstruction, Mandible/Maxilla, Subperiosteal Implant; Complete	Anthem	CG-SURG-84	
21247	Reconstruction, Mandibular Condyle W/Bone & Cartilage Autografts	Anthem	CG-SURG-84	
21255	Reconstruction, Zygomatic Arch/Glenoid Fossa W/Bone & Cartilage (Includes Obtaining Autografts)	Anthem	ANC.00008	
21256	Reconstruction, Orbit W/Osteotomies & Bone Grafts (Includes Obtaining Autografts)	Anthem	ANC.00008	
21270	Malar Augmentation, Prosthetic Matl	Anthem	ANC.00008	
21685	Hyoid Myotomy and Suspension	Anthem	SURG.00129	
21740	Reconstructive Repair, Pectus Excavatum/Carinatum; Open	Anthem	ANC.00009	
21742	Reconstructive Repair, Pectus Excavatum/Carinatum; Minimal Invasive Approach, W/O Thoracoscopy	Anthem	ANC.00009	
21743	Reconstructive Repair, Pectus Excavatum/Carinatum; Minimal Invasive Approach, W/Thoracoscopy	Anthem	ANC.00009	
22505	Manipulation, Spine, Requiring Anesthesia, Any Region	Anthem	CG-MED-65	
22852	Removal of posterior segmental instrumentation	Anthem	MCG Guidelines	

Code	Code description	Responsible party	Criteria/Guideline	Comments
22999	Unlisted Proc, Abdomen, Musculoskeletal System	Anthem	CG-SURG-99, ING-CC-0036	
27299	Unlisted Proc, Pelvis/Hip Joint	Anthem	CG-SURG-85	f
27599	Unlisted Proc, Femur/Knee	Anthem	SURG.00105	
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	Anthem	SURG.00045	
28899	Unlisted Proc, Foot/Toes	Anthem	SURG.00104	
30110	Excision, Nasal Polyp(S), Simple	Anthem	CG-SURG-87	
30115	Excision, Nasal Polyp(S), Extensive	Anthem	CG-SURG-87	
30120	Excision/Surgical Planing, Skin, Nose, Rhinophyma	Anthem	ANC.00008	
30130	Excision inferior turbinate, partial or complete, any method	Anthem	CG-SURG-87	
30140	Submucous resection inferior turbinate, partial or complete, any method	Anthem	CG-SURG-87	
30400	Rhinoplasty, Primary; Lateral & Alar Cartilages &/Or Elevation, Nasal Tip	Anthem	ANC.00008	
30410	Rhinoplasty, Primary; Complete, Ext Parts W/Bony Pyramid, Lat & Alar Cartilages &/Or Elev Nasal Tip	Anthem	ANC.00008	
30420	Rhinoplasty, Primary; W/Major Septal Repair	Anthem	ANC.00008, CG-SURG-18	
30430	Rhinoplasty, Secondary; Minor Revision (Small Amount, Nasal Tip Work)	Anthem	ANC.00008	
30435	Rhinoplasty, Secondary; Intermediate Revision (Bony Work W/Osteotomies)	Anthem	ANC.00008	
30450	Rhinoplasty, Secondary; Major Revision (Nasal Tip Work & Osteotomies)	Anthem	ANC.00008	
30465	Repair, Nasal Vestibular Stenosis (Spreader Grafting, Lateral Nasal Wall Reconstruction)	Anthem	CG-SURG-87	
30520	Septoplasty/Submucous Resection W/Wo Cartilage Scoring/Contouring/Graft	Anthem	CG-SURG-18, CG-SURG-87	
30620	Septal/Other Intranasal Dermatoplasty (Does Not Include Obtaining Graft)	Anthem	CG-SURG-18	
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ab	Anthem	CG-SURG-87	
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ab	Anthem	CG-SURG-87	
30999	Unlisted Proc, Nose	Anthem	CG-SURG-87, SURG.00157	
31237	Nasal/Sinus Endoscopy, Surgical; W/Bx, Polypectomy/Debridement (Sep Proc)	Anthem	CG-SURG-24, CG-SURG-87	
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	Anthem	CG-SURG-24	
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)	Anthem	CG-SURG-24	
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)	Anthem	CG-SURG-24	
31256	Nasal/Sinus Endoscopy, Surgical, W/Maxillary Antrostomy;	Anthem	CG-SURG-24	
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	Anthem	CG-SURG-24	

Code	Code description	Responsible party	Criteria/Guideline	Comments
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	Anthem	CG-SURG-24	
31267	Nasal/Sinus Endoscopy, Surgical, W/Maxillary Antrostomy; W/Maxillary Tissue Removal	Anthem	CG-SURG-24	
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	Anthem	CG-SURG-24	
31287	Nasal/Sinus Endoscopy, Surgical, W/Sphenoidotomy;	Anthem	CG-SURG-24	
31288	Nasal/Sinus Endoscopy, Surgical, W/Sphenoidotomy; W/Tissue Removal, Sphenoid Sinus	Anthem	CG-SURG-24	
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	Anthem	CG-SURG-73	
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	Anthem	CG-SURG-73	
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	Anthem	CG-SURG-73	
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	Anthem	CG-SURG-73	
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	Anthem	MED.00132	
32664	Thoracoscopy, Surgical; W/Thoracic Sympathectomy	Anthem	CG-MED-63	
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	Anthem	CG-SURG-61	
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	Anthem	CG-SURG-63	
33214	Repositioning, Previously Implanted Transvenous Electrode/Pacing Cardiovert-Defib Electrode	Anthem	CG-SURG-63	
33216	Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator	Anthem	CG-SURG-97	
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator	Anthem	CG-SURG-97	
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existin	Anthem	CG-SURG-63	
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary pro	Anthem	CG-SURG-63	

Code	Code description	Responsible party	Criteria/Guideline	Comments
33226	Repositioning Of Previously Implanted Cardiac Venous System (Left Ventricular) Electrode (Including Removal, Insertion And/Or Replacement Of Existing Generator)	Anthem	CG-SURG-63	
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	Anthem	CG-SURG-63	
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	Anthem	CG-SURG-63	
33230	Insertion Of Pacing Cardioverter-Defibrillator Pulse Generator Only; With Existing Dual Leads	Anthem	CG-SURG-97	
33231	Insertion Of Pacing Cardioverter-Defibrillator Pulse Generator Only; With Existing Multiple Leads	Anthem	CG-SURG-97	
33240	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead	Anthem	CG-SURG-97	
33249	Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber	Anthem	CG-SURG-63, CG-SURG-97	
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	Anthem	CG-SURG-63	
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	Anthem	CG-SURG-63	
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or	Anthem	CG-SURG-97	
33271	Insertion of subcutaneous implantable defibrillator electrode	Anthem	CG-SURG-97	
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Anthem	CG-MED-74	
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and	Anthem	MED.00115	
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision	Anthem	SURG.00032	
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Anthem	SURG.00121	
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Anthem	SURG.00121	
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Anthem	SURG.00121	
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Anthem	SURG.00121	

Code	Code description	Responsible party	Criteria/Guideline	Comments
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Anthem	SURG.00121	
33366	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Anthem	SURG.00121	
33405	Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Anthem	MCG Guidelines	
33406	Replacement, aortic valve, open, with cardiopulmonary bypass; with allograft valve (freehand)	Anthem	MCG Guidelines	
33410	Replacement, aortic valve, open, with cardiopulmonary bypass; with stentless tissue valve	Anthem	MCG Guidelines	
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus	Anthem	MCG Guidelines	
33412	Replacement, Aortic Valve; W/Transventricular Aortic Annulus Enlargement (Konno Proc)	Anthem	MCG Guidelines	
33413	Replacement, Aortic Valve; Translocation, Autologous Pulmonary Valve, W/Allograft Replacement	Anthem	MCG Guidelines	
33414	Repair, Left Ventricular Outflow Tract Obstruction, Patch Enlargement, Outflow Tract	Anthem	MCG Guidelines	
33415	Resection/Incision, Subvalvular Tissue, Discrete Subvalvular Aortic Stenosis	Anthem	MCG Guidelines	
33416	Ventriculomyotomy/Myectomy, Idiopathic Hypertrophic Subaortic Stenosis (IHSS)	Anthem	MCG Guidelines	
33417	Aortoplasty (Gusset), Supravalvular Stenosis	Anthem	MCG Guidelines	
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Anthem	SURG.00121	
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Anthem	SURG.00121	
33420	Valvotomy, Mitral Valve; Closed Heart	Anthem	MCG Guidelines	
33422	Valvotomy, Mitral Valve; Open Heart, W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33425	Valvuloplasty, Mitral Valve, W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33426	Valvuloplasty, Mitral Valve, W/Cardiopulmonary Bypass; W/Prosthetic Ring	Anthem	MCG Guidelines	
33427	Valvuloplasty, Mitral Valve, W/Cardiopulmonary Bypass; Radical Reconstruction, W/Wo Ring	Anthem	MCG Guidelines	
33430	Replacement, Mitral Valve, W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33460	Valvectomy, Tricuspid Valve, W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33463	Valvuloplasty, Tricuspid Valve; W/O Ring Insertion	Anthem	MCG Guidelines	
33464	Valvuloplasty, Tricuspid Valve; W/Ring Insertion	Anthem	MCG Guidelines	
33465	Replacement, Tricuspid Valve, W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33468	Tricuspid Valve Repositioning & Plication, Ebstein Anomaly	Anthem	MCG Guidelines	



Code	Code description	Responsible party	Criteria/Guideline	Comments
33470	Valvotomy, Pulmonary Valve, Closed Heart; Transventricular	Anthem	MCG Guidelines	
33471	Valvotomy, Pulmonary Valve, Closed Heart; Via Pulmonary Artery	Anthem	MCG Guidelines	
33474	Valvotomy, Pulmonary Valve, Open Heart; W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33475	Replacement, Pulmonary Valve	Anthem	MCG Guidelines	
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Anthem	SURG.00121	
33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR,	Anthem	SURG.00005	
33600	Closure, Atrioventricular Valve (Mitral/Tricuspid), Suture/Patch	Anthem	MCG Guidelines	
33602	Closure, Semilunar Valve (Aortic/Pulmonary), Suture/Patch	Anthem	MCG Guidelines	
33840	Excision, Coarctation, Aorta W/Wo Patent Ductus Arteriosus; W/Direct Anastomosis	Anthem	MCG Guidelines	
33845	Excision, Coarctation, Aorta W/Wo Patent Ductus Arteriosus; W/Graft	Anthem	MCG Guidelines	
33851	Excision, Coarctation, Aorta; Repair W/ Left Subclavian Artery/Prosthetic Matl	Anthem	MCG Guidelines	
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Anthem	MCG Guidelines	
33870	Transverse Arch Graft, W/Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33875	Descending Thoracic Aorta Graft, W/Wo Bypass	Anthem	MCG Guidelines	
33877	Repair, Thoracoabdominal Aortic Aneurysm W/Graft, W/Wo Cardiopulmonary Bypass	Anthem	MCG Guidelines	
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Anthem	SURG.00145	
33928	Removal and replacement of total replacement heart system (artificial heart)	Anthem	SURG.00145	
33975	Insertion, Ventricular Assist Device; Extracorporeal, Single Ventricle	Anthem	SURG.00145	
33976	Insertion, Ventricular Assist Device; Extracorporeal, Biventricular	Anthem	SURG.00145	
33979	Insertion, Ventricular Assist Device, Implantable Intracorporeal, Single Ventricle	Anthem	SURG.00145	
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	Anthem	SURG.00145	
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary	Anthem	SURG.00145	
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary byp	Anthem	SURG.00145	
33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only	Anthem	SURG.00145	
33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture	Anthem	SURG.00145	



Code	Code description	Responsible party	Criteria/Guideline	Comments
33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	Anthem	SURG.00145	
33999	Unlisted Proc, Cardiac Surgery	Anthem	SURG.00032, SURG.00121, SURG.00123	
34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretat	Anthem	CG-SURG-86	
34717	Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and devic	Anthem	CG-SURG-86	
34841	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and inte	Anthem	CG-SURG-86	
34842	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and inte	Anthem	CG-SURG-86	
34843	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and inte	Anthem	CG-SURG-86	
34844	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and inte	Anthem	CG-SURG-86	
34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modula	Anthem	CG-SURG-86	
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modula	Anthem	CG-SURG-86	
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modula	Anthem	CG-SURG-86	

Code	Code description	Responsible party	Criteria/Guideline	Comments
34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modula	Anthem	CG-SURG-86	
36260	Insertion, Implantable Intra-Arterial Infusion Pump	Anthem	CG-SURG-79	
36261	Revision, Implanted Intra-Arterial Infusion Pump	Anthem	CG-SURG-79	
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphen	Anthem	SURG.00037	
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vei	Anthem	SURG.00037	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	Anthem	ANC.00007, SURG.00037	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	Anthem	SURG.00037	
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	Anthem	SURG.00037	
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Anthem	SURG.00037	
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition	Anthem	SURG.00037	
36475	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Percutaneous, Radiofrequency; First Vein Treated	Anthem	SURG.00037	
36478	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Percutaneous, Laser; First Vein Treated	Anthem	SURG.00037	
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Anthem	SURG.00037	
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a s	Anthem	SURG.00037	
36511	Therapeutic Apheresis; White Blood Cells	Anthem	CG-MED-68	
36512	Therapeutic Apheresis; Red Blood Cells	Anthem	CG-MED-68	
36513	Therapeutic Apheresis; Platelets	Anthem	CG-MED-68	
36514	Therapeutic Apheresis; Plasma Pheresis	Anthem	CG-MED-68	

Code	Code description	Responsible party	Criteria/Guideline	Comments
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	Anthem	CG-MED-68	
36563	Insertion of Tunneled Centrally Inserted Central Venous Access Device with Subcutaneous Pump	Anthem	CG-SURG-79	
36583	Replacement, Complete, of a Tunneled Centrally Inserted Central Venous Access Device, w Sq Pump, Via Same Access	Anthem	CG-SURG-79	
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis	Anthem	CG-SURG-93	
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis	Anthem	CG-SURG-93	
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis	Anthem	CG-SURG-93	
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s),	Anthem	CG-SURG-93	
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s),	Anthem	CG-SURG-93	
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dia	Anthem	CG-SURG-93	
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	Anthem	CG-SURG-49	
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	Anthem	CG-SURG-49	

Code	Code description	Responsible party	Criteria/Guideline	Comments
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for prima	Anthem	CG-SURG-49	
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	Anthem	CG-SURG-49	
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	Anthem	CG-SURG-49	
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	Anthem	CG-SURG-49	
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	Anthem	CG-SURG-49	
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Anthem	CG-SURG-49	

Code	Code description	Responsible party	Criteria/Guideline	Comments
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for p	Anthem	CG-SURG-49	
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in additi	Anthem	CG-SURG-49	
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous ma	Anthem	SURG.00037, SURG.00062	
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquire	Anthem	CG-SURG-83	
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	Anthem	CG-SURG-107, CG-SURG-28, CG-SURG-78, RAD.00059	
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	Anthem	CG-SURG-28	
38999	Unlisted Proc, Hemic/Lymphatic System	Anthem	SURG.00154	
41512	Tongue base suspension, permanent suture technique	Anthem	SURG.00129	
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	Anthem	SURG.00129	
42145	Palatopharyngoplasty	Anthem	SURG.00129	
42299	Unlisted Proc, Palate, Uvula	Anthem	SURG.00129	
42830	Adenoidectomy, primary; under age 12	Anthem	CG-SURG-36	
42831	Adenoidectomy, Primary; Age 12+	Anthem	CG-SURG-36	
42835	Adenoidectomy, secondary; younger than age 12	Anthem	CG-SURG-36	
42836	Adenoidectomy, Secondary; Age 12+	Anthem	CG-SURG-36	
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Anthem	SURG.00106	
43280	Laparoscopy, Surgical, Esophagogastric Fundoplasty	Anthem	CG-SURG-92	
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of me	Anthem	CG-SURG-92	

Code	Code description	Responsible party	Criteria/Guideline	Comments
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Anthem	CG-SURG-92	
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	Anthem	CG-SURG-92	
43327	Esophagogastric fundoplasty partial or complete; laparotomy	Anthem	CG-SURG-92	
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	Anthem	CG-SURG-92	
43330	Esophagomyotomy; Abdominal Approach	Anthem	CG-SURG-92	
43331	Esophagomyotomy; Thoracic Approach	Anthem	CG-SURG-92	
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	Anthem	CG-SURG-92	
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	Anthem	CG-SURG-92	
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	Anthem	CG-SURG-92	
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	Anthem	CG-SURG-92	
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	Anthem	CG-SURG-92	
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	Anthem	CG-SURG-92	
43620	Gastrectomy, Total; W/Esophagoenterostomy	Anthem	MCG Guidelines	
43621	Gastrectomy, Total; W/Roux-En-Y Reconstruction	Anthem	MCG Guidelines	
43622	Gastrectomy, Total; W/Formation, Intestinal Pouch, Any Type	Anthem	MCG Guidelines	
43631	Gastrectomy, Partial, Distal; W/Gastroduodenostomy	Anthem	MCG Guidelines	
43632	Gastrectomy, Partial, Distal; W/Gastrojejunostomy	Anthem	CG-SURG-83	
43633	Gastrectomy, Partial, Distal; W/Roux-En-Y Reconstruction	Anthem	CG-SURG-83	
43634	Gastrectomy, Partial, Distal; W/Formation, Intestinal Pouch	Anthem	MCG Guidelines	
43635	Vagotomy W/Partial Distal Gastrectomy	Anthem	MCG Guidelines	
43640	Vagotomy W/Pyloroplasty, W/Wo Gastrostomy; Truncal/Selective	Anthem	MCG Guidelines	
43641	Vagotomy W/Pyloroplasty, W/Wo Gastrostomy; Parietal Cell (Highly Selective)	Anthem	MCG Guidelines	
43644	Laparoscopy, Surg, Gastric Restrictive Procedure; W Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux Limb <= 150 Cm)	Anthem	CG-SURG-83	
43645	Laparoscopy, Surgical, Gastric Restrictive Procedure; With Gastric Bypass And Small Intestine Reconstruction	Anthem	CG-SURG-83	
43659	Unlisted Proc, Laparoscopy, Stomach	Anthem	CG-SURG-83	



Code	Code description	Responsible party	Criteria/Guideline	Comments
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric ba	Anthem	CG-SURG-83	
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	Anthem	CG-SURG-83	
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Anthem	CG-SURG-83	
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device c	Anthem	CG-SURG-83	
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous	Anthem	CG-SURG-83	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Anthem	CG-SURG-83	
43842	Gastric Restrictive Proc, W/O Gastric Bypass, Morbid Obesity; Vertical-Banded Gastroplasty	Anthem	CG-SURG-83	
43843	Gastric Restrictve Proc, W/O Gastric Bypass, Morbid Obesity; Non-Vertical-Banded Gastroplasty	Anthem	CG-SURG-83	
43845	Gastric Stapling Morbid Obesity	Anthem	CG-SURG-83	
43846	Gastric Restrictive Procedure, W/Gastric Bypass, Morbid Obesity; W/Short Limb Roux-En-Y Gastroenterostomy	Anthem	CG-SURG-83	
43847	Gastric Restrictive Proc, W/Gastric Bypass, Morbid Obesity; W/Small Bowel Reconstruction	Anthem	CG-SURG-83	
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (s	Anthem	CG-SURG-83	
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Anthem	CG-SURG-83	
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Anthem	CG-SURG-83	
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	Anthem	CG-SURG-83	
43999	Unlisted Proc, Stomach	Anthem	SURG.00047, CG-SURG-83	
44050	Reduction, Volvulus, Intussusception, Int Hernia, Laparotomy	Anthem	MCG Guidelines	
44120	Enterectomy, Resection, Small Intestine; Single Resection & Anastomosis	Anthem	MCG Guidelines	
44121	Enterectomy, Resection, Small Intestine; Add'l Resection/Anastomosis	Anthem	MCG Guidelines	
44125	Enterectomy, Resection, Small Intestine; W/Enterostomy	Anthem	MCG Guidelines	
44126	Enterectomy, Resect Small Intestine Congenital Atresia, Anastomosis Prox Intestine Segmnt; W/O Taper	Anthem	MCG Guidelines	
44127	Enterectomy, Resect Small Intestine Congenital Atresia, Anastomosis Prox Intestine Segmnt; W/Taper	Anthem	MCG Guidelines	
44128	Enterectomy, Resect Small Intestine Congenital Atresia; Ea Add'l Resect & Anastomosis	Anthem	MCG Guidelines	
44140	Colectomy, Partial; W/Anastomosis	Anthem	MCG Guidelines	
44141	Colectomy, Partial; W/Skin Level Cecostomy/Colostomy	Anthem	MCG Guidelines	
44143	Colectomy, Partial; W/End Colostomy & Closure, Distal Segment	Anthem	MCG Guidelines	



Code	Code description	Responsible party	Criteria/Guideline	Comments
44144	Colectomy, Partial; W/Resection, W/Colostomy/Ileostomy & Creation, Mucofistula	Anthem	MCG Guidelines	
44145	Colectomy, Partial; W/Coloproctostomy (Low Pelvic Anastomosis)	Anthem	MCG Guidelines	
44146	Colectomy, Partial; W/Coloproctostomy (Low Pelvic Anastomosis), W/Colostomy	Anthem	MCG Guidelines	
44147	Colectomy, Partial; Abdominal & Transanal Approach	Anthem	MCG Guidelines	
44155	Colectomy, Total, Abdominal, W/Proctectomy; W/Ileostomy	Anthem	MCG Guidelines	
44156	Colectomy, Total, Abdominal, W/Proctectomy; W/Continent Ileostomy	Anthem	MCG Guidelines	
44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectom	Anthem	MCG Guidelines	
44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes	Anthem	MCG Guidelines	
44160	Colectomy, Partial, W/Removal, Terminal Ileum W/Ileocolostomy	Anthem	MCG Guidelines	
44204	Laparoscopy, Surgical; Colectomy, Partial, W/Anastomosis	Anthem	MCG Guidelines	
44205	Laparoscopy, Surgical; Colectomy, Partial, W/Removal Terminal Ileum W/Ileocolostomy	Anthem	MCG Guidelines	
44206	Lap, Surg; Colectomy, Partial, W/End Colostomy & Closure, Distal Segment	Anthem	MCG Guidelines	
44207	Lap, Surg; Colectomy, Partial, W/Anastomosis, W/Coloproctostomy	Anthem	MCG Guidelines	
44208	Lap, Surg; Colectomy, Partial, W/Anastomosis, W/Coloproctostomy, W/Colostomy	Anthem	MCG Guidelines	
44210	Lap, Surg; Colectomy, Total, Abdom, W/O Proctectomy, W/Ileostomy/Ileoproctostomy	Anthem	MCG Guidelines	
44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List	Anthem	MCG Guidelines	
45110	Proctectomy; Complete, Combined Abdominoperineal, W/Colostomy	Anthem	MCG Guidelines	
45112	Proctectomy, Combined Abdominoperineal, Pull-Through Proc	Anthem	MCG Guidelines	
45119	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic rese	Anthem	MCG Guidelines	
45120	Proctectomy, Complete, (Cong Megacolon) Abd/Perineal Approach; W/Pull-Through Proc/Anastomosis	Anthem	MCG Guidelines	
45121	Proctect, Complete, (Cong Megacolon) Abd/Perineal Approach; W/Subtotal/Total Colectomy & Multiple Bx	Anthem	MCG Guidelines	
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	Anthem	SURG.00141	
47370	Laparoscopy, Surgical, Ablation 1+ Liver Tumor(S); Radiofrequency	Anthem	CG-SURG-78	
47371	Laparoscopy, Surgical, Ablation 1+ Liver Tumor(S); Cryosurgical	Anthem	CG-SURG-78	
47380	Ablation, Open, 1+ Liver Tumor(S); Radiofrequency	Anthem	CG-SURG-78	
47381	Ablation, Open, 1+ Liver Tumor(S); Cryosurgical	Anthem	CG-SURG-78	

Code	Code description	Responsible party	Criteria/Guideline	Comments
47382	Ablation, Open, 1+ Liver Tumor(S), Percutaneous, Radiofrequency	Anthem	CG-SURG-78	
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Anthem	CG-SURG-78	
48999	Unlisted Proc, Pancreas	Anthem	CG-SURG-61	
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	Anthem	CG-SURG-61	
50300	Donor Nephrectomy; Cadaver Donor, Unilat/Bilat W/Prep & Maintenance, Allograft	Anthem	CG-TRANS-02	
50320	Donor Nephrectomy, Open, Living Donor W/O Allograft Preparation & Maintenance	Anthem	CG-TRANS-02	
50323	Backbench Standard Preparation Of Cadaver Donor Renal Allograft	Anthem	CG-TRANS-02	
50325	Backbench Standard Preparation Of Living Donor Renal Allograft (Open Or Laparoscopic)	Anthem	CG-TRANS-02	
50327	Backbench Reconstruction Of Cadaver Or Living Donor Renal Allograft Prior To Transplantation; Venous Anastomosis, Each	Anthem	CG-TRANS-02	
50328	Backbench Reconstruction Of Cadaver Or Living Donor Renal Allograft Prior To Transplantation; Arterial Anastomosis, Each	Anthem	CG-TRANS-02	
50329	Backbench Reconstruction Of Cadaver Or Living Donor Renal Allograft Prior To Transplantation; Ureteral Anastomosis, Each	Anthem	CG-TRANS-02	
50340	Recipient Nephrectomy (Sep Proc)	Anthem	CG-TRANS-02	
50360	Renal Allotransplantation, Implantation, Graft; W/O Donor & Recipient Nephrectomy	Anthem	CG-TRANS-02	
50365	Renal Allotransplantation, Implantation, Graft; W/Recipient Nephrectomy	Anthem	CG-TRANS-02	
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	Anthem	CG-SURG-61	
50547	Laparoscopy, Surgical; Donor Nephrectomy, Living Donor W/O Allograft Prep & Maintenance	Anthem	CG-TRANS-02	
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	Anthem	CG-SURG-61	
50593	Ablation, renal tumor(s), unilateral, presutaneous cryotherapy	Anthem	CG-SURG-61	
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Anthem	CG-SURG-107	
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Anthem	CG-SURG-107	
52450	Transurethral Incision, Prostate	Anthem	CG-SURG-107	
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	Anthem	CG-SURG-107	
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	Anthem	CG-SURG-107	

Code	Code description	Responsible party	Criteria/Guideline	Comments
52649	Laser enucleation of the prostate with morcellation including control of postoperative bleeding, complete (vasectomy, me	Anthem	CG-SURG-107	
53447	Removal & Replacement, Inflatable Sphincter W/Pump, Reservoir, Cuff, Same Session	Anthem	SURG.00010	
53850	Transurethral Destruction, Prostate Tissue; Microwave Thermotherapy	Anthem	CG-SURG-107	
53852	Transurethral Destruction, Prostate Tissue; Radiofrequency Thermotherapy	Anthem	CG-SURG-107	
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Anthem	CG-SURG-107	
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Anthem	CG-SURG-107	
53899	Unlisted Proc, Urinary System	Anthem	CG-SURG-107	
54125	Amputation, Penis; Complete	Anthem	CG-SURG-27	
54360	Plastic Operation, Penis To Correct Angulation	Anthem	ANC.00009	
54400	Insertion, Penile Prosthesis; Non-Inflatable (Semi-Rigid)	Anthem	CG-SURG-12, CG-SURG-27	
54401	Insertion, Penile Prosthesis; Inflatable (Self-Contained)	Anthem	CG-SURG-12, CG-SURG-27	
54405	Insertion, (Multi-Component) Inflatable Penile Prosthesis	Anthem	CG-SURG-12, CG-SURG-27	
54410	Removal & Replacement, Multi-Component Inflatable Penile Prosthesis, Same Session	Anthem	CG-SURG-12	
54411	Removal & Replacement, Multi-Component Inflatable Penile Prosthesis, Infected, W/ Irrig & Debride	Anthem	CG-SURG-12	
54416	Removal & Replacement, Non-Inflatable (Semi-Rigid)/Inflatable (Self-Contained) Penile Prosthesis	Anthem	CG-SURG-12	
54417	Removal & Replace, Non-Inflatable/Inflatable Penile Prosthesis Infect, W/Irrig & Debride	Anthem	CG-SURG-12	
54440	Plastic Operation, Penis, Injury	Anthem	ANC.00009	
54520	Orchiectomy, Simple, W/Wo Prosthesis, Scrotal/Inguinal Approach	Anthem	CG-SURG-27	
54660	Insertion, Testicular Prosthesis (Sep Proc)	Anthem	CG-SURG-27	
54690	Laparoscopy, Surgical; Orchiectomy	Anthem	CG-SURG-27	
55180	Scrotoplasty; Complicated	Anthem	CG-SURG-27	
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	Anthem	CG-SURG-107, CG-SURG-61	
56625	Vulvectomy Simple; Complete	Anthem	CG-SURG-27	
56800	Plastic Repair, Introitus	Anthem	ANC.00009, CG-SURG-27	
56805	Clitoroplasty, Intersex State	Anthem	ANC.00009, CG-SURG-27	
56810	Perineoplasty, Repair, Perineum, Nonobstetrical (Sep Proc)	Anthem	ANC.00009	
57110	Vaginectomy, Complete Removal, Vaginal Wall	Anthem	CG-SURG-27	
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	Anthem	MCG Guidelines	
57270	Repair of enterocele, abdominal approach (separate procedure)	Anthem	MCG Guidelines	
57280	Colpopexy, abdominal approach	Anthem	MCG Guidelines	
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	Anthem	MCG Guidelines	
57284	Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach	Anthem	MCG Guidelines	
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	Anthem	MCG Guidelines	
57291	Construction, Artificial Vagina; W/O Graft	Anthem	ANC.00009, CG-SURG-27	

Code	Code description	Responsible party	Criteria/Guideline	Comments
57292	Construction, Artificial Vagina; W/Graft	Anthem	ANC.00009, CG-SURG-27	
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	Anthem	CG-SURG-27	
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	Anthem	CG-SURG-27	
57335	Vaginoplasty, Intersex State	Anthem	ANC.00009	
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Anthem	MCG Guidelines	
58150	Total Abdominal Hysterectomy W/Wo Removal Tube(S)/Ovary(S)	Anthem	CG-SURG-27	
58152	Total Abdominal Hysterectomy W/Wo Removal Tube(S)/Ovary(S); W/Colpo-Urethrocystopexy	Anthem	MCG Guidelines	
58180	Supracervical Abdominal Hysterectomy, W/Wo Removal Tube(S)/Ovary(S)	Anthem	MCG Guidelines	
58200	Total Abdominal Hysterectomy, W/Partial Vaginect, W/Pelvic Node Sample, W/Wo Rem Tubes/Ovaries	Anthem	MCG Guidelines	
58210	Radical Abdominal Hysterectomy W/Bilat Pelvic Lymphadenectomy	Anthem	MCG Guidelines	
58240	Pelvic Exenteration, Gynecologic Malignancy	Anthem	MCG Guidelines	
58260	Vaginal hysterectomy, for uterus 250 g or less;	Anthem	MCG Guidelines	
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	Anthem	MCG Guidelines	
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	Anthem	MCG Guidelines	
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra typ	Anthem	MCG Guidelines	
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	Anthem	MCG Guidelines	
58275	Vaginal Hysterectomy, W/Total/Partial Vaginectomy	Anthem	MCG Guidelines	
58280	Vaginal Hysterectomy; W/Total/Partial Vaginectomy; W/Repair, Enterocele	Anthem	MCG Guidelines	
58285	Vaginal Hysterectomy; Radical	Anthem	MCG Guidelines	
58290	Vaginal Hysterectomy, Uterus >250 Gms;	Anthem	MCG Guidelines	
58291	Vaginal Hysterectomy, Uterus >250 Gms; W/Removal, Tube(S) &/Or Ovary(S)	Anthem	MCG Guidelines	
58292	Vaginal Hysterectomy, Uterus >250 Gms; W/Removal, Tube(S) &/Or Ovary(S) W/Repair Of Enterocele	Anthem	MCG Guidelines	
58293	Vaginal Hysterectomy, Uterus >250 Gms; W/Colpo-Urethrocystopexy W/Wo Endoscopic Control	Anthem	MCG Guidelines	
58294	Vaginal Hysterectomy, Uterus >250 Gms; W/Repair Of Enterocele	Anthem	MCG Guidelines	
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Anthem	MCG Guidelines	
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Anthem	MCG Guidelines	
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Anthem	MCG Guidelines	
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Anthem	MCG Guidelines	
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node	Anthem	MCG Guidelines	

Code	Code description	Responsible party	Criteria/Guideline	Comments
58550	Laparoscopy, Surg, W/Vaginal Hysterectomy, Uterus 250gms/<	Anthem	MCG Guidelines	
58552	Laparoscopy, Surg, W/Vaginal Hysterectomy, Uterus 250gms/<; W/Removal, Tube(S) &/Or Ovary(S)	Anthem	CG-SURG-27	
58553	Laparoscopy, Surg, W/Vaginal Hysterectomy, Uterus >250gms	Anthem	MCG Guidelines	
58554	Laparoscopy, Surg, W/Vaginal Hysterectomy, Uterus >250gms; W/Remove Tube(S) &/Or Ovary(S)	Anthem	CG-SURG-27	
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	Anthem	CG-SURG-27	
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less;with removal of tube(s) and/or ovary (s)	Anthem	MCG Guidelines	
58572	Laparoscopy; surgical, with total hysterectomy, for uterus greater than 250 g	Anthem	CG-SURG-27	
58573	Laparoscopy; surgical, with total hysterectomy, for uterus greater than 250 g, with removal of tube(s) and/or ovary (s)	Anthem	CG-SURG-27	
58953	Bilat Salpingo-Oophorect W/Omentect, Total Abdom Hyster & Radical Dissect Debulk	Anthem	MCG Guidelines	
58954	Bilat Salping-Oophorec W/Omentec, TI Abd Hyst & Radcl Dissec, Debul; W/Pelv & Ltd Paraaortic Lymp	Anthem	MCG Guidelines	
58956	Bilateral Salpingo-Oophorectomy With Total Omentectomy, Total Abdominal Hysterectomy For Malignancy	Anthem	MCG Guidelines	
58999	Unlisted Proc, Female Genital System (Nonobstetrical)	Anthem	TRANS.00037	
59525	Subtotal/Total Hysterectomy After Cesarean Delivery	Anthem	MCG Guidelines	
61215	Insertion, Subq Reservoir/Pump/Infusion System, Ventricular Catheter	Anthem	CG-SURG-79	
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	Anthem	CG-SURG-76, CG-SURG-106	
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angiop	Anthem	CG-SURG-76, CG-SURG-106	
61720	Creation, Lesion, Stereotactic W/Burr Hole(S), Single/Multiple; Globus Pallidus/Thalamus	Anthem	CG-SURG-108	
61850	Twist Drill/Burr Hole(S), Implantation, Neurostimulator Electrodes, Cortical	Anthem	SURG.00026	
61860	Craniectomy/Craniotomy, Implantation, Neurostimulator Electrodes, Cerebral, Cortical	Anthem	SURG.00026	
61863	Burr Hole Craniotomy with Implantation of Subcortical Electrode Array, wo Intraop Microelectrode Recording; First Array	Anthem	SURG.00026	
61864	Burr Hole Craniotomy w Implantation of Subcortical Electrode Array, wo Intraop Microelectrode Recording; ea addl Array	Anthem	SURG.00026	
61867	Burr Hole Craniotomy with Implantation of Subcortical Electrode Array, w Intraop Microelectrode Recording; First Array	Anthem	SURG.00026	
61868	Burr Hole Craniotomy w Implantation of Subcortical Electrode Array, w Intraop Microelectrode Recording; ea addl Array	Anthem	SURG.00026	
61870	Craniectomy, Implantation, Neurostimulator Electrodes, Cerebellar; Cortical	Anthem	SURG.00026	



Code	Code description	Responsible party	Criteria/Guideline	Comments
61885	Subq Placement Cranial Neurostimulator Pulse Generator/Receiver; W/Connection Sngle Electrode Array	Anthem	SURG.00007, SURG.00026, SURG.00112	
61886	Subq Placement Cranial Neurostimulator Pulse Generator/Receiver; W/Connection 2+ Electrode Arrays	Anthem	SURG.00026	
62350	Implant/Revisn/Reposition Intrathecal/Epidural Catheter, Externl Reservoir/Infusion Pump; W/O Laminect	Anthem	CG-SURG-79	
62351	Implant/Revisn/Reposition Intrathecal/Epidural Catheter, Externl Reservoir/Infusion Pump; W/Laminect	Anthem	CG-SURG-79	
62360	Implantation/Replace, Device, Intrathecal/Epidural Drug Infusion; Subq Reservoir	Anthem	CG-SURG-79	
62361	Implantation/Replace, Device, Intrathecal/Epidural Drug Infusion; Non-Programmable Pump	Anthem	CG-SURG-79	
62362	Implantation/Replace, Device, Intrathecal/Epidural Drug Infusion; Programmable Pump	Anthem	CG-SURG-79	
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Anthem	SURG.00142	
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	Anthem	SURG.00007, SURG.00112	
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Anthem	SURG.00158, SURG.00112	
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Anthem	SURG.00112, SURG.00129	
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Anthem	SURG.00112	
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Anthem	CG-MED-79, SURG.00112, SURG.00158	
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupl	Anthem	CG-SURG-70, CG-SURG-95, SURG.00158	
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Anthem	SURG.00142	
64716	Neuroplasty &/Or Transposition; Cranial Nerve (Specify)	Anthem	ANC.00008, SURG.00096	
64732	Transection/Avulsion; Supraorbital Nerve	Anthem	ANC.00008	
64734	Transection/Avulsion; Infraorbital Nerve	Anthem	ANC.00008	
64736	Transection/Avulsion; Mental Nerve	Anthem	ANC.00008	
64738	Transection/Avulsion; Inferior Alveolar Nerve, Osteotomy	Anthem	ANC.00008	
64740	Transection/Avulsion; Lingual Nerve	Anthem	ANC.00008	
64742	Transection/Avulsion; Facial Nerve, Differential/Complete	Anthem	ANC.00008	
64771	Transection/Avulsion, Other Cranial Nerve, Extradural	Anthem	SURG.00096	
64772	Transection/Avulsion, Other Spinal Nerve, Extradural	Anthem	SURG.00096	
64787	Implantation, Nerve End Into Bone/Muscle	Anthem	SURG.00096	
64818	Sympathectomy, Lumbar	Anthem	CG-MED-63	

Code	Code description	Responsible party	Criteria/Guideline	Comments
64864	Suture, Facial Nerve; Extracranial	Anthem	ANC.00008	
64865	Suture, Facial Nerve; Infratemporal, W/Wo Grafting	Anthem	ANC.00008	
64866	Anastomosis; Facial-Spinal Accessory	Anthem	ANC.00008	
64868	Anastomosis; Facial-Hypoglossal	Anthem	ANC.00008	
64999	Unlisted Proc, Nervous System	Anthem	SURG.00026, SURG.00073, SURG.00096, SURG.00155	
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Anthem	SURG.00095	
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Anthem	SURG.00095	
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Anthem	SURG.00103	
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more s	Anthem	SURG.00070	
67900	Repair, Brow Ptosis, (Supraciliary/Mid-Forehead/Coronal Approach)	Anthem	SURG.00096, CG-SURG-03	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	Anthem	CG-SURG-03	
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Anthem	CG-SURG-03	
67903	Repair, Blepharoptosis; (Tarso) Levator Resection/Advancement, Int Approach	Anthem	CG-SURG-03	
67904	Repair, Blepharoptosis; (Tarso) Levator Resection/Advancement, Ext Approach	Anthem	CG-SURG-03	
67906	Repair, Blepharoptosis; Superior Rectus W/Fascial Sling	Anthem	CG-SURG-03	
67908	Repair, Blepharoptosis; Conjunctivo-Tarso-Muller's Muscle-Levator Resection	Anthem	CG-SURG-03	
69090	Ear Piercing	Anthem	ANC.00008	
69300	Otoplasty, Protruding Ear, W/Wo Size Reduction	Anthem	ANC.00008	
69710	Implantation/Replacement, Electromagnetic Bone Conduction Hearing Device, Temporal Bone	Anthem	CG-SURG-82	
69714	Implantation, Osseointegrated Implant Temporal Bone; W/O Mastoidectomy	Anthem	CG-SURG-82	
69715	Implantation, Osseointegrated Implant, Temporal Bone; W/Mastoidectomy	Anthem	CG-SURG-82	
69717	Replacement, Osseointegrated Implant, Temporal Bone; W/O Mastoidectomy	Anthem	CG-SURG-82	
69718	Replacement, Osseointegrated Implant, Temporal Bone; W/Mastoidectomy	Anthem	CG-SURG-82	
69949	Unlisted Proc, Inner Ear	Anthem	CG-SURG-81	
69955	Total Facial Nerve Decompression &/Or Repair, (May Include Graft)	Anthem	ANC.00008	
77299	Unlisted Proc, Therapeutic Radiology Clinical Treatment Planning	Anthem	THER-RAD.00012	
77399	Unlisted Proc, Radiation/Physics/Dosimetry & Treatment Devices & Special Services	Anthem	THER-RAD.00012	
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Anthem	CG-MED-87	
78699	Unlisted Nervous System Proc, Dx Nuclear Medicine	Anthem	CG-MED-87	



Code	Code description	Responsible party	Criteria/Guideline	Comments
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed)	Anthem	CG-MED-77	
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed)	Anthem	CG-MED-87	
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed)	Anthem	CG-MED-77	
80145	Adalimumab	Anthem	LAB.00030	
80230	Infliximab	Anthem	LAB.00030	
80280	Vedolizumab	Anthem	LAB.00030	
81220	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg, Cystic Fibrosis) Gene Analysis; Common Variants (Eg, Acmg/Acog Guidelines)	Anthem	CG-GENE-13	
81329	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed	Anthem	CG-GENE-13	
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score	Anthem	LAB.00033	
87999	Unlisted Microbiology Proc	Anthem	GENE.00053, CG-LAB-03	
89337	Cryopreservation, mature oocyte(s)	Anthem	CG-MED-66	
89344	Storage, (Per Year); Reproductive Tissue, Testicular/Ovarian	Anthem	CG-MED-66	
89346	Storage, (Per Year); Oocyte	Anthem	CG-MED-66	
89354	Thawing of Cryopreserved; Reproductive Tissue, Testicular/Ovarian	Anthem	CG-MED-66	
89356	Thawing of Cryopreserved; Oocytes, Each Aliquot	Anthem	CG-MED-66	
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Anthem	BEH.00002	
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Anthem	BEH.00002	
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Anthem	BEH.00002	
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	Anthem	MED.00125	

Code	Code description	Responsible party	Criteria/Guideline	Comments
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	Anthem	MED.00125	
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Anthem	MED.00090	
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events	Anthem	CG-MED-74	
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events	Anthem	CG-MED-74	
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care	Anthem	MED.00115	
93745	Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establ	Anthem	MED.00055	
93580	Perc Transcatheter Closure, Congenital Interatrial Communication W/Implant	Anthem	SURG.00032	
93799	Unlisted Cardiovascular Service/Proc	Anthem	RAD.00057, SURG.00128, MED.00053, MED.00111	
93998	Unlisted Noninvasive Vascular Diagnostic Study	Anthem	MED.00116	
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recor	Anthem	MED.00002	
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	Anthem	CG-MED-46	
95955	Electroencephalogram (Eeg) During Nonintracranial Surgery	Anthem	CG-MED-46	
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst	Anthem	SURG.00007	
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst	Anthem	SURG.00007	
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Anthem	MED.00013	

Code	Code description	Responsible party	Criteria/Guideline	Comments
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Anthem	MED.00013	
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	Anthem	MED.00004	
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	Anthem	MED.00004	
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	Anthem	MED.00004	
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	Anthem	MED.00004	
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	Anthem	MED.00004	
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	Anthem	MED.00004	
97039	Unlisted modality (specify type and time if constant attendance)	Anthem	SURG.00008	
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) and	Anthem	CG-BEH-02	
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	Anthem	CG-BEH-02	
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	Anthem	CG-BEH-02	
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	Anthem	CG-BEH-02	
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	Anthem	CG-BEH-02	

Code	Code description	Responsible party	Criteria/Guideline	Comments
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	Anthem	CG-BEH-02	
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	Anthem	CG-BEH-02	
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	Anthem	CG-BEH-02	
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	Anthem	CG-MED-73	
99199	Unlisted Proc, Special Service/Report	Anthem	CG-ANC-08, MED.00133	
99600	Unlisted Home Visit Service/Procedure	Anthem	CG-MED-71	
0014M	Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1[TIMP-1]), using immuno	Anthem	LAB.00019	
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma myTAIHEART, TAI Diagnostics, Inc, TAI Diagnostics, Inc	Anthem	TRANS.00025	
0058T	Cryopreservation; reproductive tissue, ovarian	Anthem	CG-MED-66	
0071T	Ultrasound Ablation of Uterine Leiomyomata inc MR Guidance	Anthem	MED.00057	
0072T	Ultrasound Ablation of Uterine Leiomyomata inc MR Guidance; Vol>=200 CC	Anthem	MED.00057	
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score Molecular Microscope® MMDx—Heart, Kashi Clinical Laboratories	Anthem	TRANS.00025	
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Anthem	LAB.00015	
0092U	Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of malignancy	Anthem	LAB.00011	
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia	Anthem	LAB.00040	
0248U	Oncology (brain), spheroid cell culture in a 3D microenvironment, 12 drug panel, tumor-response prediction for each drug	Anthem	LAB.00003	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysi	Anthem	GENE.00052	
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy	Anthem	SURG.00045	
0102T	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle	Anthem	SURG.00045	
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA [when specified for heart transplant rejection]	Anthem	TRANS.00025	
0166U	Liver disease, 10 biochemical assays (+2-macroglobulin, haptoglobin, apolipoprotein A1, bilirubin, GGT, ALT, AST, triglycerides, cholesterol, fasting glucose) and biometric a	Anthem	LAB.00019	
0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis	Anthem	CG-GENE-13	
0174U	Oncology (solid tumor), mass spectrometric 30 protein targets, formalin-fixed paraffin-embedded tissue, prognostic and predictive algorithm reported as likely, unlikely, or un	Anthem	LAB.00011	
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork	Anthem	SURG.00103	
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	Anthem	SURG.00092	
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space	Anthem	SURG.00103	
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	Anthem	SURG.00071	
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	Anthem	SURG.00071	
0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg, Scrambler Therapy), Each Treatment Session (Includes Placement Of Electrodes)	Anthem	DME.00011	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming	Anthem	CG-SURG-83	
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator	Anthem	CG-SURG-83	
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator	Anthem	CG-SURG-83	
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator	Anthem	CG-SURG-83	
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator	Anthem	CG-SURG-83	
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed	Anthem	CG-SURG-83	
0335T	Insertion of sinus tarsi implant	Anthem	SURG.00104	
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Anthem	SURG.00121	
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	Anthem	SURG.00139	
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	Anthem	SURG.00139	
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	Anthem	SURG.00139	
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	Anthem	SURG.00139	
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assis	Anthem	CG-BEH-02	
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with	Anthem	CG-BEH-02	
0376T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)	Anthem	SURG.00103	
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	Anthem	MED.00057	



Code	Code description	Responsible party	Criteria/Guideline	Comments
0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium and intraoperative pachymetry, when performed (Report medication separately)	Anthem	CG-SURG-105	
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency	Anthem	SURG.00077	
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	Anthem	SURG.00153	
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	Anthem	SURG.00153	
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	Anthem	SURG.00153	
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	Anthem	SURG.00153	
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	Anthem	SURG.00153	
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	Anthem	SURG.00153	
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	Anthem	SURG.00153, SURG.00153	
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	Anthem	SURG.00153	
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	Anthem	SURG.00153	
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility m	Anthem	SURG.00153	
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	Anthem	SURG.00153	
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when p	Anthem	CG-SURG-107	
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	Anthem	SURG.00103	



Code	Code description	Responsible party	Criteria/Guideline	Comments
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	Anthem	SURG.00103	
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)	Anthem	SURG.00101	
0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure)	Anthem	SURG.00129	
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator	Anthem	SURG.00129	
0468T	Removal of chest wall respiratory sensor electrode or electrode array	Anthem	SURG.00129	
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	Anthem	SURG.00103	
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	Anthem	MED.00110	
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	Anthem	SURG.00121	
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	Anthem	SURG.00121	
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	Anthem	MED.00132	
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	Anthem	MED.00132	
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all ca	Anthem	CG-SURG-49	
0510T	Removal of sinus tarsi implant	Anthem	SURG.00104	
0511T	Removal and reinsertion of sinus tarsi implant	Anthem	SURG.00104	
0512T	Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound	Anthem	SURG.00045	
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])	Anthem	SURG.00152	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	Anthem	SURG.00152	
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only	Anthem	SURG.00152	
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left ventricular pacing	Anthem	SURG.00152	
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)	Anthem	SURG.00152	
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode	Anthem	SURG.00152	
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	Anthem	SURG.00152	
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left	Anthem	SURG.00152	
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	Anthem	SURG.00037	
0533T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; includes set-up, patient training, configuration of monitor, data upload, analysis and initial report configuration, download review	Anthem	MED.00101	
0534T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; set-up, patient training, configuration of monitor	Anthem	MED.00101	
0535T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; data upload, analysis and initial report configuration	Anthem	MED.00101	
0536T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; download review, interpretation and report	Anthem	MED.00101	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	Anthem	MED.00123; MED.00124	
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)	Anthem	MED.00123; MED.00124	
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	Anthem	MED.00123; MED.00124	
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	Anthem	MED.00123; MED.00124	
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	Anthem	SURG.00121	
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	Anthem	SURG.00121	
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	Anthem	SURG.00139	
0548T	Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy	Anthem	SURG.00010	
0549T	Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy	Anthem	SURG.00010	
0550T	Transperineal periurethral balloon continence device; removal, each balloon	Anthem	SURG.00010	
0551T	Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume	Anthem	SURG.00010	
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	Anthem	MED.00103	
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	Anthem	MED.00132	
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound gu	Anthem	MED.00132	
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	Anthem	SURG.00121	
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	Anthem	CG-SURG-61	
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when perf	Anthem	TRANS.00010	
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when perf	Anthem	TRANS.00010	

Code	Code description	Responsible party	Criteria/Guideline	Comments
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when perf	Anthem	TRANS.00010	
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	Anthem	SURG.00010	
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	Anthem	SURG.00010	
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	Anthem	SURG.00126	
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	Anthem	SURG.00126	
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration	Anthem	MED.00134	
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration	Anthem	MED.00134	
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without inserti	Anthem	SURG.00156	
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens	Anthem	SURG.00156	
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange	Anthem	SURG.00156	
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or	Anthem	CG-SURG-49	
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	Anthem	TRANS.00037	
0665T	Donor hysterectomy (including cold preservation); open, from living donor	Anthem	TRANS.00037	
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	Anthem	TRANS.00037	
0667T	Recipient uterus allograft transplantation from cadaver or living donor	Anthem	TRANS.00037	
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	Anthem	TRANS.00037	
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	Anthem	TRANS.00037	
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	Anthem	TRANS.00037	

Code	Code description	Responsible party	Criteria/Guideline	Comments
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	Anthem	CG-DME-46	
A7025	High Frequency Chest Wall Oscillation System Vest, Replacement For Use	Anthem	CG-DME-43	
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	Anthem	MED.00133	
A9507	Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries	Anthem	CG-MED-87	
B4164	Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - home mix	Anthem	CG-MED-89	
B4168	Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - home mix	Anthem	CG-MED-89	
B4172	Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix	Anthem	CG-MED-89	
B4176	Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix	Anthem	CG-MED-89	
B4178	Parenteral nutrition solution; amino acid, greater than 8.5%, (500 ml = 1 unit) - home mix	Anthem	CG-MED-89	
B4180	Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) - home mix	Anthem	CG-MED-89	
B4185	Parenteral nutrition solution, not otherwise specified, 10 grams lipids	Anthem	CG-MED-89	
B4187	Omegaven, 10 grams lipids	Anthem	CG-MED-89	
B4189	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix	Anthem	CG-MED-89	
B4193	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix	Anthem	CG-MED-89	
B4197	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix	Anthem	CG-MED-89	
B4199	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, over 100 grams of protein - premix	Anthem	CG-MED-89	
B4216	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) home mix per day	Anthem	CG-MED-89	
B4220	Parenteral nutrition supply kit; premix, per day	Anthem	CG-MED-89	
B4222	Parenteral nutrition supply kit; home mix, per day	Anthem	CG-MED-89	
B4224	Parenteral nutrition administration kit, per day	Anthem	CG-MED-89	
B5000	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - Aminosyn-RF, NephrAmine, RenAmine - premix	Anthem	CG-MED-89	

Code	Code description	Responsible party	Criteria/Guideline	Comments
B5100	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, HepatAmine – premix	Anthem	CG-MED-89	
B5200	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids - FreAmine-HBC - premix	Anthem	CG-MED-89	
B9004	Parenteral nutrition infusion pump, portable	Anthem	CG-MED-89	
B9006	Parenteral nutrition infusion pump, stationary	Anthem	CG-MED-89	
B9999	NOC for parenteral supplies	Anthem	CG-MED-89	
C1721	Cardioverter-defibrillator, dual chamber (implantable)	Anthem	CG-SURG-97	
C1722	Cardioverter-defibrillator, single chamber (implantable)	Anthem	CG-SURG-97	
C1726	Catheter, balloon dilatation, nonvascular	Anthem	CG-SURG-73	
C1764	Event recorder, cardiac (implantable)	Anthem	CG-MED-74	
C1767	Generator, neurostimulator (implantable), nonrechargeable	Anthem	CG-SURG-95, SURG.00026, SURG.00112, SURG.00129, SURG.00158	
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	Anthem	CG-SURG-97	
C1778	Lead, neurostimulator (implantable)	Anthem	SURG.00007, SURG.00112, SURG.00129, SURG.00158	
C1787	Patient programmer, neurostimulator	Anthem	SURG.00158, SURG.00129	
C1789	Prosthesis, breast (implantable)	Anthem	SURG.00023	
C1813	Prosthesis, penile, inflatable	Anthem	CG-SURG-27	
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	Anthem	SURG.00026	
C1821	Interspinous process distraction device (implantable)	Anthem	SURG.00092	
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	Anthem	SURG.00026	
C1839	Iris prosthesis	Anthem	SURG.00156	
C1878	Material for vocal cord medialization, synthetic (implantable)	Anthem	MED.00132	
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	Anthem	CG-SURG-97	
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	Anthem	CG-SURG-97	
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	Anthem	CG-SURG-97	
C2596	Probe, image guided, robotic, waterjet ablation	Anthem	CG-SURG-107	
C2622	Prosthesis, penile, noninflatable	Anthem	CG-SURG-27	
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	Anthem	MED.00115	
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (lis	Anthem	SURG.00011	
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area,	Anthem	SURG.00011	
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up t	Anthem	SURG.00011	



Code	Code description	Responsible party	Criteria/Guideline	Comments
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area grea	Anthem	SURG.00011	
C9073	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Anthem	ING-CC-0168	
C9727	Insertion of implants into the soft palate; minimum of 3 implants	Anthem	SURG.00129	
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance	Anthem	MED.00057	
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	Anthem	CG-SURG-107	
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	Anthem	CG-SURG-107	
C9747	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	Anthem	MED.00057	
C9749	Repair of nasal vestibular lateral wall stenosis with implant(s)	Anthem	CG-SURG-87	
C9752	Destruction of intraosseous basivertebral nerve, first two vertebral bodies, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum	Anthem	SURG.00052	
D7288	Brush biopsy	Anthem	CG-LAB-12	
D7940	Osteoplasty - For Orthognathic Deformities	Anthem	CG-SURG-84	
D7941	Osteotomy - Mandibular Rami	Anthem	CG-SURG-84	
D7943	Osteotomy - Mandibular Rami With Bone Graft; Includes Obtaining The Graft	Anthem	CG-SURG-84	
D7944	OSTEOTOMY-SEGMENTED OR SUBAPICAL	Anthem	CG-SURG-84	
D7945	osteotomy - body of mandible	Anthem	CG-SURG-84	
D7946	LeFort I (maxilla - total)	Anthem	CG-SURG-84	
D7947	Lefort I (Maxilla - Segmented)	Anthem	CG-SURG-84	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	Anthem	CG-SURG-84	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft	Anthem	CG-SURG-84	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	Anthem	CG-SURG-84	
D7995	Synthetic Graft - Mandible Or Facial Bones, By Report	Anthem	CG-SURG-84	
D7996	Implant-Mandible For Augmentation Purposes (Excluding Alveolar Ridge), By Report	Anthem	CG-SURG-84	
E0217	Water Circ Heat Pad W Pump	Anthem	DME.00037	
E0218	Fluid circulating cold pad with pump, any type	Anthem	DME.00037	
E0236	Pump For Water Circulating P	Anthem	DME.00037	
E0483	High frequency chest wall oscillation system, includes all accessories and supplies, each	Anthem	CG-DME-43	
E0616	Cardiac Event Recorder	Anthem	CG-MED-74	
E0638	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	Anthem	CG-DME-49	
E0641	Standing frame/table system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels	Anthem	CG-DME-49	
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric	Anthem	CG-DME-49	
E0650	Pneuma Compresor Non-Segment	Anthem	CG-DME-46	



Code	Code description	Responsible party	Criteria/Guideline	Comments
E0651	Pneum Compressor Segmental	Anthem	CG-DME-46	
E0652	Pneum Compres W/Cal Pressure	Anthem	CG-DME-06, CG-DME-46	
E0655	Pneumatic Appliance Half Arm	Anthem	CG-DME-46	
E0660	Pneumatic Appliance Full Leg	Anthem	CG-DME-46	
E0665	Pneumatic Appliance Full Arm	Anthem	CG-DME-46	
E0666	Pneumatic Appliance Half Leg	Anthem	CG-DME-46	
E0667	Seg Pneumatic Appl Full Leg	Anthem	CG-DME-46	
E0668	Seg Pneumatic Appl Full Arm	Anthem	CG-DME-46	
E0669	Seg Pneumatic Appli Half Leg	Anthem	CG-DME-46	
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	Anthem	CG-DME-46	
E0671	Pressure Pneum Appl Full Leg	Anthem	CG-DME-46	
E0672	Pressure Pneum Appl Full Arm	Anthem	CG-DME-46	
E0673	Pressure Pneum Appl Half Leg	Anthem	CG-DME-46	
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE	Anthem	DME.00037, CG-DME-46	
E0745	Neuromuscular Stim For Shock	Anthem	DME.00022	
E0746	Electromyograph Biofeedback	Anthem	MED.00125	
E0747	Elec Osteogen Stim Not Spine	Anthem	CG-DME-40	
E0749	Elec Osteogen Stim Implanted	Anthem	CG-DME-40	
E0760	Osteogen Ultrasound Stimltor	Anthem	CG-DME-45	
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer	Anthem	DME.00022	
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, n	Anthem	DME.00022	
E1002	Wheelchair accessory, power seating system, tilt only	Anthem	CG-DME-31	
E1006	Wheelchair accessory, power seating system, combination tilt and recline, w/o shear reduction	Anthem	CG-DME-31	
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with manual shear reduction	Anthem	CG-DME-31	
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg	Anthem	CG-DME-31	
E1010	Wheelchair accessory, addition to power seating system, power leg elevation	Anthem	CG-DME-31	
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	Anthem	CG-DME-31	
E1230	Power Operated Vehicle	Anthem	CG-DME-31	
E1239	Ped power wheelchair NOS	Anthem	CG-DME-31	
E1801	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes	Anthem	DME.00038	
E1806	Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes	Anthem	DME.00038	
E1811	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes	Anthem	DME.00038	
E1816	Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes	Anthem	DME.00038	
E1818	Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all	Anthem	DME.00038	

Code	Code description	Responsible party	Criteria/Guideline	Comments
E1821	Replacement soft interface material/cuffs for bi-directional static progressive stretch device	Anthem	DME.00038	
E1831	Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories	Anthem	DME.00038	
E1841	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and acce	Anthem	DME.00038	
E1902	Communication board, non-electronic augmentative or alternative communication device	Anthem	CG-DME-07	
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	Anthem	DME.00024	
E2300	Wheelchair accessory, power seat elevation system, any type	Anthem	CG-DME-31	
E2301	Wheelchair accessory, power standing system, any type	Anthem	CG-DME-49	
E2351	Power wheelchair accessory, electronic interface to operate speech generating device	Anthem	CG-DME-07	
E2500	Speech generating device, digitized speech, using pre-recorded messages, 8 min. or less	Anthem	CG-DME-07	
E2502	Speech generating device, digitized speech, using pre-recorded messages, 8-20 min.	Anthem	CG-DME-07	
E2504	Speech generating device, digitized speech, using pre-recorded messages, 20-40 min.	Anthem	CG-DME-07	
E2506	Speech generating device, digitized speech, using pre-recorded messages, over 40 min.	Anthem	CG-DME-07	
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling	Anthem	CG-DME-07	
E2510	Speech generating device, synthesized speech, permitting multiple methods	Anthem	CG-DME-07	
E2511	Speech generating software program, for personal computer or personal digital assistant	Anthem	CG-DME-07	
E2512	Accessory for speech generating device, mounting system	Anthem	CG-DME-07	
E2599	Accessory for speech generating device, not otherwise classified	Anthem	CG-DME-07	
G0068	Professional services for the administration of antiinfective, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s) for each infusion drug administration calendar day in the individual's home, each 15 minutes	Anthem	CG-MED-23	
G0069	Professional services for the administration of subcutaneous immunotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes	Anthem	CG-MED-23	
G0070	Professional services for the administration of chemotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes	Anthem	CG-MED-23	
G0088	Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion dr	Anthem	CG-MED-23	

Code	Code description	Responsible party	Criteria/Guideline	Comments
G0089	Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administrat	Anthem	CG-MED-23	
G0090	Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administrat	Anthem	CG-MED-23	
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	Anthem	CG-MED-73	
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes	Anthem	CG-MED-71	
G0300	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes	Anthem	CG-MED-71	
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active	Anthem	MED.00132	
G0448	Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing	Anthem	CG-SURG-97	
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes	Anthem	CG-MED-23	
H0004	Behavioral health counseling and therapy, per 15 minutes	Anthem	CG-BEH-14	
H0006	Alcohol and/or drug services; case management	Anthem	CG-BEH-14	
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	Anthem	MCG Guidelines	
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	Anthem	CG-BEH-02	
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Anthem	CG-BEH-14	
H0031	Mental health assessment, by nonphysician	Anthem	CG-BEH-02	
H0032	Mental health service plan development by nonphysician	Anthem	CG-BEH-02	
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	Anthem	CG-BEH-14	
H0046	Mental health services, not otherwise specified	Anthem	CG-BEH-02	
H2012	Behavioral health day treatment, per hour	Anthem	CG-BEH-02	
H2014	Skills training and development, per 15 minutes	Anthem	CG-BEH-02	
H2015	Comprehensive community support services, per 15 minutes	Anthem	CG-BEH-14	
H2019	Therapeutic behavioral services, per 15 minutes	Anthem	CG-BEH-02, CG-BEH-14	
H2020	Therapeutic behavioral services, per diem	Anthem	CG-BEH-14	
J0456	Azithromycin	Anthem	MED.00013	
J0470	Dimecaprol Injection	Anthem	MED.00127	
J0600	Edetate Calcium Disodium Inj	Anthem	MED.00127	
J0696	Ceftriaxone Sodium Injection	Anthem	MED.00013	

Code	Code description	Responsible party	Criteria/Guideline	Comments
J0698	Cefotaxime Sodium Injection	Anthem	MED.00013	
J0895	Injection, deferoxamine mesylate, 500 mg	Anthem	MED.00127	
J1450	Injection, fluconazole, 200 mg	Anthem	MED.00013	
J1815	Injection, insulin, per 5 units	Anthem	MED.00128	
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units	Anthem	MED.00128	
J1956	Injection, levofloxacin, 250 mg	Anthem	MED.00013	
J2280	Injection, moxifloxacin, 100 mg	Anthem	MED.00013	
J2540	Penicillin G Potassium Inj	Anthem	MED.00013	
J2787	Riboflavin 5-phosphate, ophthalmic solution, up to 3 ml	Anthem	CG-SURG-105	
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	Anthem	MED.00129	
J3520	Edetate Disodium Per 150 Mg	Anthem	MED.00127	
J8499	Oral Prescrip Drug Non, Chemo	Anthem	MED.00085	
J8999	Oral Prescription Drug Chemo	Anthem	MED.00085	
K0010	Stnd Wt Frame Power Whlchr	Anthem	CG-DME-31	
K0011	Stnd Wt Pwr Whlchr W Control	Anthem	CG-DME-31	
K0012	Ltwt Portbl Power Whlchr	Anthem	CG-DME-31	
K0013	Custom motorized/power wheelchair base	Anthem	CG-DME-31	
K0014	Other Power Whlchr Base	Anthem	CG-DME-31	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	Anthem	MED.00055	
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	Anthem	CG-DME-31	
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Anthem	CG-DME-31	
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POU	Anthem	CG-DME-31	

Code	Code description	Responsible party	Criteria/Guideline	Comments
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Anthem	CG-DME-31	
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Anthem	CG-DME-31	
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 30	Anthem	CG-DME-31	
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUND	Anthem	CG-DME-31	
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUD	Anthem	CG-DME-31	
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Anthem	CG-DME-31	
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POU	Anthem	CG-DME-31	
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 60	Anthem	CG-DME-31	
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUN	Anthem	CG-DME-31	
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCL	Anthem	CG-DME-31	

Code	Code description	Responsible party	Criteria/Guideline	Comments
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 3	Anthem	CG-DME-31	
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 P	Anthem	CG-DME-31	
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Anthem	CG-DME-31	
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Anthem	CG-DME-31	
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUD	Anthem	CG-DME-31	
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Anthem	CG-DME-31	
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POU	Anthem	CG-DME-31	
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 60	Anthem	CG-DME-31	
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCL	Anthem	CG-DME-31	
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 P	Anthem	CG-DME-31	



Code	Code description	Responsible party	Criteria/Guideline	Comments
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO	Anthem	CG-DME-31	
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 PO	Anthem	CG-DME-31	
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Anthem	CG-DME-31	
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Anthem	CG-DME-31	
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUD	Anthem	CG-DME-31	
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Anthem	CG-DME-31	
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POU	Anthem	CG-DME-31	
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	Anthem	CG-DME-31	
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCL	Anthem	CG-DME-31	
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUND	Anthem	CG-DME-31	
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 P	Anthem	CG-DME-31	
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLU	Anthem	CG-DME-31	
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INC	Anthem	CG-DME-31	
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	Anthem	CG-DME-31	
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria	Anthem	CG-DME-31	
K1002	Cranial electrotherapy stimulation (CES) system, includes all supplies and accessories, any type	Anthem	DME.00011	



Code	Code description	Responsible party	Criteria/Guideline	Comments
K1004	Low frequency ultrasonic diathermy treatment device for home use, includes all components and accessories	Anthem	DME.00041	
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes	Anthem	OR-PR.00006	
K1014	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	Anthem	OR-PR.00003	
L1499	Spinal Orthosis Nos	Anthem	DME.00025	
L2006	Knee ankle foot device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated	Anthem	OR-PR.00007	
L2999	Lower Extremity Orthosis Nos	Anthem	OR-PR.00006	
L5856	Elec knee-shin swing/stance	Anthem	OR-PR.00003	
L5857	Elec knee-shin swing only	Anthem	OR-PR.00003	
L5858	Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only	Anthem	OR-PR.00003	
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	Anthem	OR-PR.00003	
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	Anthem	OR-PR.00003	
L5973	Endoskeletal Ankle Foot System, Microprocessor Controlled Feature, Dorsiflexion And/Or Plantar Flexion Control, Includes	Anthem	OR-PR.00003	
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH,	Anthem	CG-OR-PR-05	
L6677	Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow	Anthem	CG-OR-PR-05	
L6880	Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)	Anthem	CG-OR-PR-05	
L6881	AUTOMATIC GRASP FEATURE, ADDITION TO UPPER LIMB ELECTRIC PROSTHETIC TERMINAL	Anthem	CG-OR-PR-05	
L6882	Microprocessor control feature, addition to upper limb prosthesis terminal device	Anthem	CG-OR-PR-05	
L6925	Wrist Disart Myoelectronic C	Anthem	CG-OR-PR-05	
L6935	Below Elbow Myoelectronic Ct	Anthem	CG-OR-PR-05	
L6945	Elbow Disart Myoelectronic C	Anthem	CG-OR-PR-05	
L6955	Above Elbow Myoelectronic Ct	Anthem	CG-OR-PR-05	
L6965	Shldr Disartic Myoelectronic	Anthem	CG-OR-PR-05	
L6975	Interscap-Thor Myoelectronic	Anthem	CG-OR-PR-05	
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	Anthem	CG-OR-PR-05	
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	Anthem	CG-OR-PR-05	
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	Anthem	CG-OR-PR-05	
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	Anthem	CG-OR-PR-05	

Code	Code description	Responsible party	Criteria/Guideline	Comments
L7180	Electronic Elbow Utah Myoele	Anthem	CG-OR-PR-05	
L7181	Electronic elbow simultaneous	Anthem	CG-OR-PR-05	
L7190	Elbow Adolescent Myoelectron	Anthem	CG-OR-PR-05	
L7191	Elbow Child Myoelectronic Ct	Anthem	CG-OR-PR-05	
L8600	Implantable breast prosthesis, silicone or equal	Anthem	SURG.00023	
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	Anthem	MED.00132	
L8614	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	Anthem	CG-SURG-81	
L8619	Cochlear Implant, External Speech Processor And Controller, Integrated System, Replacement	Anthem	CG-SURG-81	
L8627	Cochlear Implant, External Speech Processor, Component, Replacement	Anthem	CG-SURG-81	
L8628	Cochlear Implant, External Controller Component, Replacement	Anthem	CG-SURG-81	
L8679	Implantable neurostimulator, pulse generator, any type	Anthem	SURG.00158, SURG.00112, CG-SURG-95	
L8680	Implantable neurostimulator electrode, each	Anthem	CG-SURG-08, CG-SURG-95, SURG.00112, CG-SURG-70, SURG.00007, SURG.00026, SURG.00129, SURG.00158	
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	Anthem	SURG.00129	
L8682	Implantable neurostimulator radiofrequency receiver	Anthem	SURG.00026, CG-SURG-08	
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Anthem	SURG.00158, SURG.00026	
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladde	Anthem	CG-SURG-08	
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	Anthem	SURG.00007, SURG.00026, SURG.00112	
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	Anthem	SURG.00007, SURG.00026, SURG.00112, CG-SURG-95	
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	Anthem	SURG.00026	
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	Anthem	SURG.00026, SURG.00129, CG-SURG-70	
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	Anthem	CG-SURG-82	
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each	Anthem	CG-SURG-82	
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	Anthem	CG-SURG-82	
L8699	Prosthetic Implant Nos	Anthem	CG-SURG-27	
M0300	Iv Chelationtherapy	Anthem	MED.00127	
Q2026	Injection, Radiesse, 0.1ml	Anthem	MED.00132	
Q2028	Injection, sculptra, 0.5 mg	Anthem	MED.00132	
Q4205	Membrane Graft or Membrane Wrap, per sq cm	Anthem	SURG.00011	
Q4206	Fluid Flow or Fluid GF, 1 cc	Anthem	SURG.00011	
Q4208	Novafix, per sq cm	Anthem	SURG.00011	
Q4211	Amnion Bio or AxoBioMembrane, per sq cm	Anthem	SURG.00011	
Q4212	AlloGen, per cc	Anthem	SURG.00011	
Q4213	Ascent, 0.5 mg	Anthem	SURG.00011	
Q4214	Cellesta Cord, per sq cm	Anthem	SURG.00011	
Q4215	Axolotl Ambient or Axolotl Cryo, 0.1 mg	Anthem	SURG.00011	

Code	Code description	Responsible party	Criteria/Guideline	Comments
Q4216	Artacent Cord, per sq cm	Anthem	SURG.00011	
Q4217	WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per sq cm	Anthem	SURG.00011	
Q4218	SurgiCORD, per sq cm	Anthem	SURG.00011	
Q4219	SurgiGRAFT-DUAL, per sq cm	Anthem	SURG.00011	
Q4220	BellaCell HD or Surederm, per sq cm	Anthem	SURG.00011	
Q4221	Amnio Wrap2, per sq cm	Anthem	SURG.00011	
Q4222	ProgenaMatrix, per sq cm	Anthem	SURG.00011	
Q4226	MyOwn Skin, includes harvesting and preparation procedures, per sq cm	Anthem	MED.00110	
Q4227	AmnioCoreTM, per sq cm	Anthem	SURG.00011	
Q4228	BioNextPATCH, per sq cm	Anthem	SURG.00011	
Q4229	Cogenex Amniotic Membrane, per sq cm	Anthem	SURG.00011	
Q4230	Cogenex Flowable Amnion, per 0.5 cc	Anthem	SURG.00011	
Q4231	Corplex P, per cc	Anthem	SURG.00011	
Q4232	Corplex, per sq cm	Anthem	SURG.00011	
Q4233	SurFactor or NuDyn, per 0.5 cc	Anthem	SURG.00011	
Q4234	XCellerate, per sq cm	Anthem	SURG.00011	
Q4235	AMNIOREPAIR or AltiPly, per sq cm	Anthem	SURG.00011	
Q4236	carePATCH, per sq cm	Anthem	SURG.00011	
Q4237	Cryo-Cord, per sq cm	Anthem	SURG.00011	
Q4238	Derm-Maxx, per sq cm	Anthem	SURG.00011	
Q4239	Amnio-Maxx or Amnio-Maxx Lite, per sq cm	Anthem	SURG.00011	
Q4240	CoreCyte, for topical use only, per 0.5 cc	Anthem	SURG.00011	
Q4241	PolyCyte, for topical use only, per 0.5 cc	Anthem	SURG.00011	
Q4242	AmnioCyte Plus, per 0.5 cc	Anthem	SURG.00011	
Q4244	Procenta, per 200 mg	Anthem	SURG.00011	
Q4245	AmnioText, per cc	Anthem	SURG.00011	
Q4246	CoreText or ProText, per cc	Anthem	SURG.00011	
Q4247	Amniotext patch, per sq cm	Anthem	SURG.00011	
Q4248	Dermacyte Amniotic Membrane Allograft, per sq cm	Anthem	SURG.00011	
Q4249	Amniply, for topical use only, per square centimeter	Anthem	SURG.00011	
Q4250	Amnioamp-mp, per square centimeter	Anthem	SURG.00011	
Q4254	Novafix dl, per square centimeter	Anthem	SURG.00111	
Q4255	Reguard, for topical use only, per square centimeter	Anthem	SURG.00011	
S2066	Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral	Anthem	SURG.00023	
S2067	Breast reconstruction of a single breast with “stacked” deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral	Anthem	SURG.00023	
S2068	Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral	Anthem	SURG.00023	
S2080	Laser-assisted uvulopalatoplasty (LAUP)	Anthem	SURG.00129	
S2117	Arthroereisis, subtalar	Anthem	SURG.00104	
S2118	Metal-on-metal total hip resurfacing including acetabular and femoral components	Anthem	CG-SURG-85	

Code	Code description	Responsible party	Criteria/Guideline	Comments
S2120	Low Density Lipoprotein(Ldl)	Anthem	CG-MED-68	
S2202	Echosclerotherapy	Anthem	SURG.00037	
S2230	Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear	Anthem	SURG.00084	
S2235	Implantation of auditory brain stem implant	Anthem	CG-SURG-81	
S2300	Arthroscopy, Shoulder, Surgi	Anthem	SURG.00043	
S2342	Nasal endoscopy for post-operative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(	Anthem	CG-SURG-24	
S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar	Anthem	SURG.00071	
S8040	Topographic Brain Mapping	Anthem	MED.00002	
S8080	Scintimammography	Anthem	CG-MED-87	
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT cod	Anthem	CG-REHAB-08, CG-MED-71	
S9124	Nursing care, in the home; by licensed practical nurse, per hour	Anthem	CG-REHAB-08, CG-MED-71	
S9338	Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Anthem	CG-MED-23, ING-CC-0003	
S9355	Home infusion therapy, chelation therapy	Anthem	MED.00127	
S9357	Home infusion therapy, enzyme replacement intravenous therapy; (e.g., Imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Anthem	CG-MED-23, ING-CC-0018; ING-CC-0021; ING-CC-0022; ING-CC-0023; ING-CC-0024; ING-CC-0025; ING-CC-0051	
S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula, and nursing visits coded separately) per diem	Anthem	CG-MED-89	
S9365	Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula, and nursing visits coded separately) per diem	Anthem	CG-MED-89	

Code	Code description	Responsible party	Criteria/Guideline	Comments
S9366	Home infusion therapy, total parenteral nutrition (TPN); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula, and nursing visits coded separately) per diem	Anthem	CG-MED-89	
S9367	Home infusion therapy, total parenteral nutrition (TPN); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula, and nursing visits coded separately) per diem	Anthem	CG-MED-89	
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula, and nursing visits coded separately) per diem	Anthem	CG-MED-89	
S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy (do not use with home infusion codes for hourly dosi	Anthem	MED.00013	
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every three hours	Anthem	MED.00013	
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours	Anthem	MED.00013	
S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours	Anthem	MED.00013	
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours	Anthem	MED.00013	
S9503	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every six hours	Anthem	MED.00013	
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every four hours	Anthem	MED.00013	
T1000	Private duty/independent nursing service(s) - licensed, up to 15 minutes	Anthem	CG-REHAB-08	
T1002	RN services, up to 15 minutes	Anthem	CG-REHAB-08	
T1003	LPN/LVN services, up to 15 minutes	Anthem	CG-REHAB-08	
T1030	Nursing Care, In The Home, By Registered Nurse, Per Diem	Anthem	CG-REHAB-08, CG-MED-71	
T1031	Nursing Care, In The Home, By Licensed Practical Nurse, Per Diem	Anthem	CG-REHAB-08, CG-MED-71	
T1505	Electronic medication compliance management device, includes all components and accessories, not otherwise classified	Anthem	CG-ANC-08	
V2788	Presbyopia correcting function of intraocular lens	Anthem	SURG.00061	
V5298	Hearing Aid, Not Otherwise Classified	Anthem	CG-SURG-82	

Code	Code description	Responsible party	Criteria/Guideline	Comments
Reviewed by CarelonRx, Inc.:*				
Code	Code description	Responsible party	Criteria/Guideline	Comments
90281	Immune Globulin (Ig), Human, Im Use	CarelonRx	ING-CC-0003, ING-CC-0039	
90283	Immune Globulin (Igiv), Human, Iv Use	CarelonRx	ING-CC-0003	
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100mg, each	CarelonRx	ING-CC-0003	
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	CarelonRx	ING-CC-0007	
C9047	Injection, caplacizumab-yhdp, 1 mg	CarelonRx	ING-CC-0137	
C9071	Injection, viltolarsen, 10 mg	CarelonRx	ING-CC-0172	
C9072	Injection, immune globulin (asceniv), 500 mg	CarelonRx	ING-CC-0003	
C9257	Injection, bevacizumab, 0.25 mg	CarelonRx	ING-CC-0072	
J0129	Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	CarelonRx	ING-CC-0078	
J0135	Injection, ad	CarelonRx	ING-CC-0062	
J0178	Injection, aflibercept, 1 mg	CarelonRx	ING-CC-0072	
J0179	Injection, brolocizumab-dblI, 1 mg	CarelonRx	ING-CC-0072	
J0180	Agalsidase beta injection	CarelonRx	ING-CC-0021	
J0202	Injection, alemtuzumab, 1 mg	CarelonRx	ING-CC-0009	
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg	CarelonRx	ING-CC-0018	
J0222	Injection, patisiran, 0.1 mg	CarelonRx	ING-CC-0082; ING-CC-0084	
J0223	Injection, givosiran, 0.5 mg	CarelonRx	ING-CC-0154	
J0256	Injection, alpha 1-proteinase inhibitor (human), not otherwise specified, 10 mg	CarelonRx	ING-CC-0073	
J0257	Injection, alpha 1 proteinase inhibitor (human), (GLASSIA), 10 mg	CarelonRx	ING-CC-0073	
J0485	Injection, belatacept, 1 mg	CarelonRx	ING-CC-0076	
J0490	Injection, belimumab, 10 mg	CarelonRx	ING-CC-0028	
J0517	Injection, benralizumab, 1 mg	CarelonRx	ING-CC-0043	
J0567	Injection, cerliponase alfa, 1 mg	CarelonRx	ING-CC-0012	
J0570	Buprenorphine implant, 74.2 mg	CarelonRx	ING-CC-0030	
J0584	Injection, burosumab-twza 1 mg	CarelonRx	ING-CC-0081	
J0585	Injection, Onabotulinumtoxina, 1 Unit	CarelonRx	ING-CC-0032	
J0586	Injection, Abobotulinumtoxina, 5 Units	CarelonRx	ING-CC-0032	
J0587	Injection, Rimabotulinumtoxinb, 100 Units	CarelonRx	ING-CC-0032	
J0588	Injection, incobotulinumtoxinA, 1 unit	CarelonRx	ING-CC-0032	
J0593	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)	CarelonRx	ING-CC-0034	
J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	CarelonRx	ING-CC-0034	
J0597	Injection, c-1 esterase inhibitor (human), berinert, 10 units	CarelonRx	ING-CC-0034	
J0598	Injection, c-1 esterase inhibitor (human), cinryze, 10 units	CarelonRx	ING-CC-0034	
J0599	Injection, C-1 esterase inhibitor (human), (Haegarda), 10 units	CarelonRx	ING-CC-0034	
J0638	Injection, canakinumab, 1 mg	CarelonRx	ING-CC-0064	
J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	CarelonRx	ING-CC-0062	
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg	CarelonRx	ING-CC-0017	
J0791	Injection, crizanlizumab-tmca, 5 mg	CarelonRx	ING-CC-0153	
J0800	Corticotropin Injection	CarelonRx	ING-CC-0004	



Code	Code description	Responsible party	Criteria/Guideline	Comments
J0887	Injection, epoetin beta, 1 microgram, (for esrd on dialysis)	CarelonRx	ING-CC-0001	
J0888	Injectin, epoetin beta, 1 microgram, (for non esrd use)	CarelonRx	ING-CC-0001	
J0896	Injection, luspatercept-aamt, 0.25 mg	CarelonRx	ING-CC-0156	
J1290	Injection, ecallantide, 1 mg	CarelonRx	ING-CC-0034	
J1300	Injection, eculizumab, 10 mg	CarelonRx	ING-CC-0041	
J1301	Injection, edaravone, 1 mg	CarelonRx	ING-CC-0049	
J1303	Injection, ravulizumab-cwvz, 10 mg	CarelonRx	ING-CC-0041	
J1322	Injection, elosulfase alfa, 1mg	CarelonRx	ING-CC-0022	
J1325	Epoprostenol Injection	CarelonRx	ING-CC-0067	
J1428	Injection, eteplirsen, 10 mg	CarelonRx	ING-CC-0044	
J1429	Injection, golodirsen, 10 mg	CarelonRx	ING-CC-0152	
J1437	Injection, ferric derisomaltose, 10 mg	CarelonRx	ING-CC-0182	
J1438	Etanercept Injection	CarelonRx	ING-CC-0062	
J1439	Injection, ferric carboxymaltose, 1mg	CarelonRx	ING-CC-0182	
J1458	INJECTION, GALSULFASE, 1 MG	CarelonRx	ING-CC-0023	
J1595	Injection, glatiramer acetate, 20 mg	CarelonRx	ING-CC-0014	
J1602	Injection, golimumab, 1 mg, for intravenous use	CarelonRx	ING-CC-0062	
J1628	Injection, guselkumab, 1 mg	CarelonRx	ING-CC-0050	
J1632	Injection, brexanolone, 1 mg	CarelonRx	ING-CC-0140	
J1675	Injection, histrelin acetate, 10 mcg	CarelonRx	ING-CC-0061	
J1743	Injection, idursulfase, 1 mg	CarelonRx	ING-CC-0024	
J1744	Injection, icatibant, 1 mg	CarelonRx	ING-CC-0034	
J1745	Injection, infliximab, excludes biosimilar, 10 mg	CarelonRx	ING-CC-0062	
J1746	Injection, ibalizumab-uiyk, 10 mg	CarelonRx	ING-CC-0047	
J1750	Injection, Iron Dextran, 50mg	CarelonRx	ING-CC-0182	
J1756	Injection, Iron Sucrose, 1 Mg	CarelonRx	ING-CC-0182	
J1786	Injection, imiglucerase, 10 units	CarelonRx	ING-CC-0051	
J1823	Injection, inebilizumab-cdon, 1 mg	CarelonRx	ING-CC-0170	
J1826	Injection, interferon beta-1a, 30 mcg	CarelonRx	ING-CC-0014	
J1830	Interferon Beta-1b / .25 Mg	CarelonRx	ING-CC-0014	
J1931	Laronidase injection	CarelonRx	ING-CC-0025	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	CarelonRx	ING-CC-0015; ING-CC-0061; ING-CC-0102	
J2170	INJECTION, MECASERMIN, 1 MG	CarelonRx	ING-CC-0045	
J2182	Injection, mepolizumab, 1 mg	CarelonRx	ING-CC-0043	
J2278	Injection, ziconotide, 1 mcg	CarelonRx	ING-CC-0040	
J2323	Imjection, natalizumab, 1 mg	CarelonRx	ING-CC-0020	
J2326	Injection, nusinersen, 0.1 mg	CarelonRx	ING-CC-0048	
J2350	Injection, ocrelizumab, 1 mg	CarelonRx	ING-CC-0011	
J2357	Injection, omalizumab, 5 mg	CarelonRx	ING-CC-0033	
J2503	Injection, pegaptanib sodium, 0.3 mg	CarelonRx	ING-CC-0072	
J2505	Injection, pegfilgrastim, 6 mg [Neulasta]	CarelonRx	ING-CC-0002	
J2507	Injection, pegloticase, 1 mg	CarelonRx	ING-CC-0057	
J2778	Injection, ranibizumab, 0.1 mg	CarelonRx	ING-CC-0072	
J2786	Injection, reslizumab, 1 mg	CarelonRx	ING-CC-0043	
J2793	Injection, Rilonacept, 1 Mg	CarelonRx	ING-CC-0064	
J2820	Injection, sargramostim (GM-CSF), 50 mcg [Leukine, Prokine]	CarelonRx	ING-CC-0002	
J2840	Injection, sebelipase alfa, 1 mg	CarelonRx	ING-CC-0037	
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	CarelonRx	ING-CC-0182	
J2940	Injection, somatrem, 1 mg	CarelonRx	ING-CC-0068	
J2941	Injection, somatropin, 1 mg	CarelonRx	ING-CC-0068	
J3032	Injection, eptinezumab-jjmr, 1 mg	CarelonRx	ING-CC-0160	
J3060	Injection, taliglucerase alfa, 10 units	CarelonRx	ING-CC-0051	
J3110	Teriparatide injection	CarelonRx	ING-CC-0038	
J3111	Injection, romosozumab-aqqg, 1 mg	CarelonRx	ING-CC-0139	
J3241	Injection, teprotumumab-trbw, 10 mg	CarelonRx	ING-CC-0162	



Code	Code description	Responsible party	Criteria/Guideline	Comments
J3245	Injection, tildrakizumab, 1 mg	CarelonRx	ING-CC-0050	
J3285	Injection, treprostinil, 1 mg	CarelonRx	ING-CC-0067	
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	CarelonRx	ING-CC-0177	
J3315	Injection, Triptorelin Pamoate, 3.75 Mg	CarelonRx	ING-CC-0061	
J3316	Injection, triptorelin, extended-release, 3.75 mg	CarelonRx	ING-CC-0061	
J3357	Ustekinumab, for subcutaneous injection, 1 mg	CarelonRx	ING-CC-0063	
J3358	Ustekinumab, for intravenous injection, 1 mg	CarelonRx	ING-CC-0063	
J3380	Injection, vedolizumab, 1 mg	CarelonRx	ING-CC-0071	
J3385	Injection, velaglucerase alfa, 100 units	CarelonRx	ING-CC-0051	
J3397	Injection, vestronidase alfa-vjbk, 1 mg	CarelonRx	ING-CC-0013	
J3489	Injection, zoledronic acid, 1 mg	CarelonRx	ING-CC-0019	
J7170	Injection, emicizumab-kxwh, 0.5 mg	CarelonRx	ING-CC-0065	
J7175	Injection, factor x, (human), 1 i.u.	CarelonRx	ING-CC-0065	
J7177	Injection, human fibrinogen concentrate (Fibryga), 1 mg	CarelonRx	ING-CC-0065	
J7178	Injection, human fibrinogen concentrate, not otherwise specified, 1 mg	CarelonRx	ING-CC-0065	
J7179	Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rco	CarelonRx	ING-CC-0065	
J7180	Injection, factor XIII (antihemophilic factor, human), 1 IU	CarelonRx	ING-CC-0065	
J7181	Injection, factor xiii a-subunit, (recombinant), per iu	CarelonRx	ING-CC-0065	
J7182	Injection, factor viii, (antihemophilic factor, recombinant), (novoeight), per iu	CarelonRx	ING-CC-0065	
J7183	Injection, von Willebrand factor complex (human), Wilate, 1 IU vWF:RCO	CarelonRx	ING-CC-0065	
J7185	Injection, Factor Viii (Antihemophilic Factor, Recombinant) (Xyntha), Per I.U.	CarelonRx	ING-CC-0065	
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII i.u.	CarelonRx	ING-CC-0065	
J7187	Injection, von Willebrand factor complex (Humate-P), per IU vWF-RCO	CarelonRx	ING-CC-0065	
J7188	Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.	CarelonRx	ING-CC-0065	
J7189	Factor VIIa (antihemophilic Factor, recombinant), per 1 mcg	CarelonRx	ING-CC-0065	
J7190	Factor Viii	CarelonRx	ING-CC-0065, ING-CC-0149	
J7191	Factor Viii (Porcine)	CarelonRx	ING-CC-0065	
J7192	Factor Viii (Antihemophilic Factor, Recombinant) Per I.U., Not Otherwise Specified	CarelonRx	ING-CC-0065, ING-CC-0065	
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU	CarelonRx	ING-CC-0065	
J7194	Factor Ix Complex	CarelonRx	ING-CC-0065	
J7195	Factor IX (antihemophilic factor, recombinant) per IU	CarelonRx	ING-CC-0065	
J7198	Anti-Inhibitor	CarelonRx	ING-CC-0065	
J7200	Injection, factor ix, (antihemophilic factor, recombinant), rixubis, per iu	CarelonRx	ING-CC-0065	
J7201	Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1 IU	CarelonRx	ING-CC-0065	
J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.	CarelonRx	ING-CC-0065	
J7203	Injection Factor IX, (antihemophilic factor, recombinant), glycopegylated, (Rebinyn), 1 IU	CarelonRx	ING-CC-0065	
J7204	Injection, Factor VIII, antihemophilic factor (recombinant), (Esperoct), glycopegylated-exei, per IU	CarelonRx	ING-CC-0065	

Code	Code description	Responsible party	Criteria/Guideline	Comments
J7205	Injection, factor viii fc fusion (recombinant), per iu	CarelonRx	ING-CC-0065	
J7207	Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.	CarelonRx	ING-CC-0065	
J7208	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	CarelonRx	ING-CC-0065	
J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.	CarelonRx	ING-CC-0065	
J7210	Injection, Factor VIII, (antihemophilic factor, recombinant), (AfstylA), 1 IU	CarelonRx	ING-CC-0065	
J7211	Injection, Factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU	CarelonRx	ING-CC-0065	
J7212	Factor viia (antihemophilic factor, recombinant)-incw (sevenfact), 1 microgram	CarelonRx	ING-CC-0149	
J7311	Injection, fluocinolone acetonide, intravitreal implant (Retisert), 0.01 mg	CarelonRx	ING-CC-0031	
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg	CarelonRx	ING-CC-0031	
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	CarelonRx	ING-CC-0031	
J7314	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	CarelonRx	ING-CC-0031	
J7316	Injection, ocriplasmin, 0.125 mg	CarelonRx	ING-CC-0070	
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml	CarelonRx	ING-CC-0035	
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	CarelonRx	ING-CC-0163	
J7352	Afamelanotide implant, 1 mg	CarelonRx	ING-CC-0159	
J7686	Treprostinil, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, 1.74 mg	CarelonRx	ING-CC-0067	
J7999	Compounded drug, not otherwise classified	CarelonRx	ING-CC-0036	
J9202	Goserelin Acetate Implant	CarelonRx	ING-CC-0061	
J9210	Injection, emapalumab-lzsg, 1 mg	CarelonRx	ING-CC-0087	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	CarelonRx	ING-CC-0061; ING-CC-0102	
J9218	Leuprolide Acetate Injeciton	CarelonRx	ING-CC-0061	
J9225	Histrelin implant (Vantas), 50 mg	CarelonRx	ING-CC-0061	
J9226	Histrelin implant (supprelin LA), 50 mg	CarelonRx	ING-CC-0061	
J9312	Injection, rituximab, 10 mg	CarelonRx	ING-CC-0075	
Q0138	Injection, Ferumoxytol, For Treatment Of Iron Deficiency Anemia, 1 Mg (Non-Esrd Use)	CarelonRx	ING-CC-0182	
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	CarelonRx	ING-CC-0014	
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	CarelonRx	ING-CC-0014	
Q4074	Iloprost, Inhalation Solution, Fda-Approved Final Product, Non-Compounded, Administered Through Dme, Unit Dose Form, Up	CarelonRx	ING-CC-0067	
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	CarelonRx	ING-CC-0062	
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	CarelonRx	ING-CC-0062	
Q5109	Injection, infliximab-qbtX, biosimilar, (Ixifi), 10 mg	CarelonRx	ING-CC-0062	
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	CarelonRx	ING-CC-0075	
Q5119	Injection, rituximab-pvvr, biosimilar, (RUXIENCE), 10 mg	CarelonRx	ING-CC-0075	
Q5121	Injection, infliximab-axxq, biosimilar, (AVSOLA), 10 mg	CarelonRx	ING-CC-0062	

Code	Code description	Responsible party	Criteria/Guideline	Comments
S0013	Esketamine, nasal spray, 1 mg	CarelonRx	ING-CC-0086	

Reviewed by multiple areas based on diagnosis:

Code	Code description	Responsible party	Criteria/Guideline	Comments
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma Cxbladder™ Detect, Pacific Edge Diagnostics USA, Ltd.	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00056	
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma Cxbladder™ Monitor, Pacific Edge Diagnostics USA, Ltd	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00056	
0016M	Oncology (bladder), mRNA, microarray gene expression profiling of 209 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like) Decipher Bladder TURBT®, Decipher Biosciences, Inc	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00056	
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements Guardant360® CDx, Guardant Health Inc, Guardant Health Inc	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00049	
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue Oncotype MAP™ PanCancer Tissue Test, Paradigm Diagnostics, Inc, Paradigm Diagnostics, Inc	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
20974	Electrical Stimulation To Aid Bone Healing; Noninvasive (Nonoperative)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine, CG-DME-40	
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging, Guidance; cervicothoracic	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine	

Code	Code description	Responsible party	Criteria/Guideline	Comments
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging, Guidance; lumbosacral	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine	
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging, Guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code f	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine	
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging, Guidance	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine	
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging, Guidance	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine	
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging, Guidance	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine	
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single le	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, SURG.00052	
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral, including fluoroscopic guidance; 1 or mor	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, SURG.00052	
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, SURG.00111	
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, SURG.00092	
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, SURG.00092	
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Carelon Medical Benefits Management	Carelon Medical Benefits Management MSK: Spine, SURG.00092	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine, SURG.00092	
30117	Excision/Destruction, Intranasal Lesion; Int Approach	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, SURG.00157	

Code	Code description	Responsible party	Criteria/Guideline	Comments
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59	
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical GI & SOC, CG-MED-59, CG-SURG-101	
43499	Unlisted Proc, Esophagus	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy, SURG.00047	
45560	Repair of rectocele (separate procedure)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
55899	Unlisted Proc, Male Genital System	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy, MED.00057, SURG.00028, SURG.00045, CG-SURG-27	
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
57260	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
57268	Repair of enterocele, vaginal approach (separate procedure)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Surgical SOC, MCG Guidelines	
62263	Lysis, Perq, Epidural Adhesions, Solution Injection/Mechanical W/Radiologic Localization; 2 Days/>	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, SURG.00072	
62264	Lysis, Perq Epidural Adhesions, Solution Injection/Mechanical W/Radiologic Localization; 1 Day	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, SURG.00072	
62281	Injection/Infusion Neurolytic Substance, W/Wo Therapeutic Substance; Epidural Cervical/Thoracic	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, SURG.00072	
62282	Injection/Infusion Neurolytic Substance; Epidural, Lumbar/Caudal	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, SURG.00072	
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural inj	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, SURG.00071	
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine, SURG.00071	
63185	Laminectomy with rhizotomy; 1 or 2 segments	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine, CG-SURG-08	
63190	Laminectomy with rhizotomy; more than 2 segments	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Spine, CG-SURG-08	
63655	Laminectomy, Implantation, Neurostimulator Electrodes, Plate/Paddle, Epidural	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, CG-SURG-66, CG-SURG-08	
64510	Injection, Anesthetic Agent; Stellate Ganglion (Cervical Sympathetic)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain	
64520	Injection, Anesthetic Agent; Lumbar/Thoracic (Paravertebral Sympathetic)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, CG-MED-63, SURG.00140	
64640	Destruction, Neurolytic; Other Peripheral Nerve/Branch	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management MSK: Pain, SURG.00096, SURG.00100, SURG.00142, SURG.00100	



Code	Code description	Responsible party	Criteria/Guideline	Comments
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent works	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiology & Cardiology	
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstati	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiology & Cardiology	
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiology & Cardiology	
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiology & Cardiology	
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiology & Cardiology	
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiology & Cardiology	
77402	Radiation Treatment Delivery, Single Area, Single/Parallel Opposed Ports; Up To 5 Mev	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy	
77407	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple bl	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy	
77412	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy	
77770	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy	
77771	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy	
78803	Radiopharmaceutical Localization, Tumor; Tomographic (Spect)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Radiation Therapy, CG-MED-87	
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81222	Cftr (Cystic Fibrosis Transmembrane, Conductance Regulator) (Eg, Cystic Fibrosis) Gene Analysis; Duplication/Deletion Variants	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13, GENE.00036, CG-GENE-13	
81223	Cftr (Cystic Fibrosis Transmembrane, Conductance Regulator) (Eg, Cystic Fibrosis) Gene Analysis; Full Gene Sequence	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13, GENE.00036, CG-GENE-13	

Code	Code description	Responsible party	Criteria/Guideline	Comments
81224	Cftr (Cystic Fibrosis Transmembrane, Conductance Regulator) (Eg, Cystic Fibrosis) Gene Analysis; Intron 8 Poly-T Analysis (Eg, Male Infertility)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13, GENE.00036, CG-GENE-13	
81240	F2 (Prothrombin, Coagulation Factor II) (Eg, Hereditary Hypercoagulability) Gene Analysis, 20210G>A Variant	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00046	
81245	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg, Acute Myeloid Leukemia), Gene Analysis, Internal Tandem Duplication (ItD) Variants (Ie, Exons 14, 15)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00041	
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00004	
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81291	Mthfr (5,10-Methylenetetrahydrofolate Reductase) (Eg, Hereditary Hypercoagulability) Gene Analysis, Common Variants (Eg, 677T, 1298C)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00010, GENE.00047	
81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81313	PCA3/KLK3 (prostate, Cancer antigen 3 [non-protein, Coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate, Cancer)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00009	
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (eg, exons 12, 18)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-14	
81324	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00033	
81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00033	



Code	Code description	Responsible party	Criteria/Guideline	Comments
81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00033	
81328	SLCO1B1 (solute, Carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00038	
81400	MOLECULAR PATHOLOGY PROCEDURE LEVEL 1	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, GENE.00038, CG-GENE-13, GENE.00046	
81401	MOLECULAR PATHOLOGY PROCEDURE LEVEL 2	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-BEH-01, CG-GENE-07, GENE.00003, CG-GENE-13, CG-GENE-14, GENE.00023, GENE.00028, GENE.00036, GENE.00037	
81403	MOLECULAR PATHOLOGY PROCEDURE LEVEL 4	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-01, CG-GENE-02, CG-GENE-09, CG-GENE-13, GENE.00017, GENE.00028, GENE.00033, GENE.00034, CG-GENE-13	
81404	MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-02, CG-GENE-14, GENE.00007, CG-GENE-13, CG-GENE-17, GENE.00033, CG-GENE-18, GENE.00036, CG-GENE-13, GENE.00044	
81405	MOLECULAR PATHOLOGY PROCEDURE LEVEL 6	Carelon Medical Benefits Management or Anthem	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-10, CG-GENE-14, GENE.00003, GENE.00007, CG-GENE-13, GENE.00017, CG-GENE-17, GENE.00033, CG-GENE-18, GENE.00036, GENE.00037, CG-GENE-13	
81406	MOLECULAR PATHOLOGY PROCEDURE LEVEL 7	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-03, CG-GENE-14, GENE.00003, GENE.00007, CG-GENE-13, CG-GENE-14, GENE.00017, GENE.00018, GENE.00020, GENE.00033, GENE.00028, GENE.00039, GENE.00042, CG-GENE-13	
81407	MOLECULAR PATHOLOGY PROCEDURE LEVEL 8	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE- 09 GENE.00007 GENE.00017	
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFB1, TGFB2, COL3A1,	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFB1, TGFB2, MYH11, and COL3A1	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes.	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
81413	Cardiac ion, Channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCN	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, GENE.00052	
S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13	
S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mu	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Genetic Testing, CG-GENE-13 GENE.00017	
A9513	Lutetium Lu 177, dotatate, therapeutic, 1 mCi	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0118	

Code	Code description	Responsible party	Criteria/Guideline	Comments
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0118	
A9606	Radium ra-223 dichloride, therapeutic, per microcurie	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0112	
A9699	Radiopharmaceutical, therapeutic, not otherwise, Classified	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Radiation Therapy, ING-CC-0118	
C9065	Injection, romidepsin, non-lyophilized (e.g. liquid), 1mg	Carelon Medical Benefits Management	ING-CC-0100	
J0565	Injection, bezlotoxumab, 10 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0046	
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0001	
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0001	
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0001	
J0897	Injection, denosumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0027	
J1442	5G-CSFexcludes biosimilars, 1 microgram	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
J1447	Injection, tbo-filgrastim, 1 microgram	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
J1459	Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1460	Gamma Globulin 1 Cc Inj	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003, Carelon Medical Benefits Management: Oncology, ING-CC-0039	
J1555	Injection, immune globulin (Cuvitru), 100 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1556	Injection, immune globulin (bivigam), 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1558	Injection, immune globulin (xembify), 100 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1559	Injection, immune globulin (hizentra), 100 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1560	Gamma Globulin > 10 Cc Inj	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003, Carelon Medical Benefits Management: Oncology, ING-CC-0039	
J1561	Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1568	Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g.	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1569	Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003	
J1930	Injection, lanreotide, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0142	
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0058	
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0058	
J2562	Injection, Plerixafor, 1 Mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0089	
J2796	Injection, Romiplostim, 10 Micrograms	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0111	
J3262	Injection, tocilizumab, 1 mg	Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0066	

Code	Code description	Responsible party	Criteria/Guideline	Comments
J3490	Unclassified drugs	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, MED.00085, MED.00120, MED.00129, ING-CC-0003, ING-CC-0008, ING-CC-0010, ING-CC-0014, ING-CC-0029, ING-CC-0030, ING-CC-0031, ING-CC-0034, ING-CC-0036, ING-CC-0038, ING-CC-0042, ING-CC-0050, ING-CC-0061, ING-CC-0064, ING-CC-0066, ING-CC-0069, ING-CC-0072, ING-CC-0079, ING-CC-0082, ING-CC-0104, ING-CC-0139, ING-CC-0140, ING-CC-0186, ING-CC-0187, ING-CC-0188, ING-CC-0189, ING-CC-0190, ING-CC-0191, ING-CC-0192, ING-CC-0193, ING-CC-0194	
J3590	Unclassified Biologics	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0003, ING-CC-0010, ING-CC-0029, ING-CC-0034, ING-CC-0041, ING-CC-0042, ING-CC-0050, ING-CC-0062, ING-CC-0064, ING-CC-0066, ING-CC-0072, ING-CC-0075, ING-CC-0077, ING-CC-0135, ING-CC-0137, ING-CC-0139, ING-CC-0167, ING-CC-0183, ING-CC-0186, ING-CC-0187, ING-CC-0188, ING-CC-0189, ING-CC-0190	
J9035	Bevacizumab injection	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0072, ING-CC-0107	
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0001	
Q5101	Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
Q5105	Injection, epoetin alfa, biosimilar, (retacrit) (for esrd on dialysis), 100 units	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0001	
Q5106	Injection, epoetin alfa, biosimilar, (retacrit) (for non-esrd use), 1000 units	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0001	
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0072, ING-CC-0107	
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
Q5110	Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
Q5111	Injection, pegfilgrastim-cbqv, biosimilar, (Udenyca), 0.5 mg	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
Q5118	Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0107, ING-CC-0072	
Q5120	Injection, pegfilgrastim-bmez, biosimilar, (ZIEXTENZO), 0.5 mg	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	CarelonRx or Carelon Medical Benefits Management	Carelon Medical Benefits Management: Oncology, ING-CC-0002	
C9399	Unclassified Drugs Or Biologicals	CarelonRx or Anthem	ING-CC-0003, ING-CC-0034, ING-CC-0042, ING-CC-0061, ING-CC-0066, ING-CC-0075, ING-CC-0077, ING-CC-0138, ING-CC-0140, ING-CC-0167, ING-CC-0189, ING-CC-0190, ING-CC-0191, ING-CC-0192, ING-CC-0193, SURG.00011	



# Anthem Blue Cross and Blue Shield

## GA Clinical Criteria Adoption

### 3/1/2023

**NOTE: Any Clinical Guideline not included in this standard adopted list that is needed to complete an ASO group-specific review requirement will be considered 'Adopted' for that ASO group only and for the specific type of review required. Additionally, as part of the Pre-Payment Review Program for commercial or Federal Employee Health Benefits Program (FEHBP) plans, Clinical Guidelines approved by Medical Policy and Technology Assessment Committee (MPTAC) but not included in this standard adopted list may be used to review a provider's claims when a provider's billing practices are not consistent with other providers in terms of frequency or in some other manner or for provider education and are "Adopted" for those purposes.**

#### Anthem Clinical Guidelines adopted by GA and reviewed by Anthem Blue Cross and Blue Shield

State	Clinical Guideline number	Clinical Guideline name	Clinical Guideline category	Date adopted by GA	Special notes
GA	CG-ANC-04	Ambulance Services: Air and Water	Ancillary/Miscellaneous	3/11/2008	
GA	CG-ANC-07	Inpatient Interfacility Transfers	Ancillary/Miscellaneous	7/1/2019	
GA	CG-ANC-08	Mobile Device-Based Health Management Applications	Ancillary/Miscellaneous	9/1/2020	
GA	CG-BEH-02	Adaptive Behavioral Treatment	Behavioral Health	11/18/2013	
GA	CG-BEH-14	Intensive In-home Behavioral Health Services	Behavioral Health	7/1/2016	
GA	CG-BEH-15	Activity Therapy for Autism Spectrum Disorders and Rett Syndrome	Behavioral Health	6/28/2018	
GA	CG-DME-06	Compression Devices for Lymphedema	Durable Medical Equipment	8/1/2011	
GA	CG-DME-07	Augmentative and Alternative Communication (AAC) Devices with Digitalized or Synthesized Speech Output	Durable Medical Equipment	10/6/2006	
GA	CG-DME-31	Powered Wheeled Mobility Devices	Durable Medical Equipment	1/1/2011	
GA	CG-DME-43	High Frequency Chest Compression Devices for Airway Clearance	Durable Medical Equipment	5/1/2018	
GA	CG-DME-44	Electric Tumor Treatment Field (TTF)	Durable Medical Equipment	6/28/2018	
GA	CG-DME-45	Ultrasound Bone Growth Stimulation	Durable Medical Equipment	9/20/2018	
GA	CG-DME-46	Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities in the Home Setting	Durable Medical Equipment	3/1/2019	
GA	CG-DME-49	Standing Frames	Durable Medical Equipment	7/7/2021	
GA	CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	Genetics	4/24/2019	
GA	CG-GENE-10	Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies	Genetics	9/4/2019	

GA	CG-GENE-11	Genotype Testing for Individual Genetic Polymorphisms to Determine Drug-Metabolizer Status	Genetics	9/4/2019	
GA	CG-GENE-13	Genetic Testing for Inherited Diseases	Genetics	2/5/2020	
GA	CG-GENE-14	Gene Mutation Testing for Cancer Susceptibility and Management	Genetics	2/5/2020	
GA	CG-GENE-15	Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP), Attenuated FAP and MYH-associated Polyposis	Genetics	2/5/2020	
GA	CG-GENE-16	BRCA Genetic Testing	Genetics	2/5/2020	
GA	CG-GENE-18	Genetic Testing for TP53 Mutations	Genetics	2/5/2020	
GA	CG-GENE-19	Measurable Residual Disease Assessment in Lymphoid Cancers Using Next Generation Sequencing	Genetics	2/5/2020	
GA	CG-GENE-22	Gene Expression Profiling for Managing Breast Cancer Treatment	Genetics	4/7/2021	
GA	CG-LAB-03	Tropism Testing for HIV Management	Laboratory	8/1/2011	
GA	CG-LAB-13	Skin Nerve Fiber Density Testing	Laboratory	6/28/2018	
GA	CG-MED-19	Custodial Care	Medicine	1/8/2008	
GA	CG-MED-23	Home Health	Medicine	1/1/2018	
GA	CG-MED-26	Neonatal Levels of Care	Medicine	1/8/2008	
GA	CG-MED-38	Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer	Medicine	3/25/2008	
GA	CG-MED-55	Site of Care: Advanced Radiologic Imaging	Medicine	9/1/2017	
GA	CG-MED-59	Upper Gastrointestinal Endoscopy in Adults	Medicine	11/1/2018	
GA	CG-MED-68	Therapeutic Apheresis	Medicine	12/27/2017	
GA	CG-MED-69	Inhaled Nitric Oxide	Medicine	6/28/2018	
GA	CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	Medicine	9/20/2018	
GA	CG-MED-74	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Medicine	9/20/2018	
GA	CG-MED-78	Anesthesia Services for Interventional Pain Management Procedures	Medicine	10/1/2022	
GA	CG-MED-83	Site of Care: Specialty Pharmaceuticals	Medicine	4/24/2019	
GA	CG-MED-89	Home Parenteral Nutrition	Medicine	11/1/2021	
GA	CG-MED-90	Chelation Therapy	Medicine	7/6/2022	
GA	CG-OR-PR-05	Myoelectric Upper Extremity Prosthetic Devices	Orthotics/Prosthetics	10/6/2006	
GA	CG-REHAB-08	Private Duty Nursing in the Home Setting	Rehabilitation	1/31/2008	
GA	CG-SURG-03	Blepharoplasty, Blepharoptosis Repair and Brow Lift	Surgery	1/31/2008	
GA	CG-SURG-08	Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury	Surgery	5/14/2008	
GA	CG-SURG-12	Penile Prosthesis Implantation	Surgery	8/1/2011	
GA	CG-SURG-18	Septoplasty	Surgery	10/6/2006	
GA	CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS)	Surgery	1/1/2011	
GA	CG-SURG-27	Gender Affirming Surgery	Surgery	8/1/2011	
GA	CG-SURG-28	Transcatheter Uterine Artery Embolization	Surgery	4/1/2012	
GA	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	Surgery	8/1/2021	

GA	CG-SURG-52	Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services	Surgery	10/1/2020	
GA	CG-SURG-61	Cryosurgical, Radiofrequency or Laser Ablation to Treat Solid Tumors Outside the Liver	Surgery	12/27/2017	
GA	CG-SURG-63	Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure	Surgery	12/27/2017	
GA	CG-SURG-71	Reduction Mammoplasty	Surgery	5/1/2018	
GA	CG-SURG-73	Balloon Sinus Ostial Dilation	Surgery	6/28/2018	
GA	CG-SURG-75	Transanal Endoscopic Microsurgical (TEM) Excision of Rectal Lesions	Surgery	6/28/2018	
GA	CG-SURG-78	Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies	Surgery	6/28/2018	
GA	CG-SURG-79	Implantable Infusion Pumps	Surgery	6/28/2018	
GA	CG-SURG-81	Cochlear Implants and Auditory Brainstem Implants	Surgery	9/20/2018	
GA	CG-SURG-82	Bone-Anchored and Bone Conduction Hearing Aids	Surgery	9/20/2018	
GA	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Surgery	10/31/2018	
GA	CG-SURG-84	Mandibular/Maxillary (Orthognathic) Surgery	Surgery	9/20/2018	
GA	CG-SURG-86	Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection	Surgery	10/31/2018	
GA	CG-SURG-88	Mastectomy for Gynecomastia	Surgery	9/20/2018	
GA	CG-SURG-89	Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia	Surgery	9/20/2018	
GA	CG-SURG-92	Paraesophageal Hernia Repair	Surgery	7/1/2019	
GA	CG-SURG-93	Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction	Surgery	7/1/2019	
GA	CG-SURG-97	Cardioverter-Defibrillators	Surgery	6/24/2019	
GA	CG-SURG-99	Panniculectomy, Abdominoplasty	Surgery	5/9/2019	
GA	CG-SURG-105	Corneal Collagen Cross-Linking	Surgery	2/5/20/20	
GA	CG-SURG-106	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	Surgery	2/5/20/20	
GA	CG-SURG-107	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)	Surgery	9/1/2020	
GA	CG-SURG-108	Stereotactic Radiofrequency Pallidotomy	Surgery	4/15/2020	
GA	CG-TRANS-02	Kidney Transplantation	Transplants	2/26/2008	
GA	CG-TRANS-03	Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation	Transplants	9/20/2018	

#### Specialty Pharmacy Drugs

NOTE: As of 6/15/2019, non-oncology drugs are reviewed by Anthem Pharmacy Utilization Management (UM) Operations

#### AIM Specialty Health® (AIM)



AIM Specialty Health, a separate company, is a nationally recognized leader delivering specialty benefits management on behalf of GA for certain health plan members. **March 2023 AIM Specialty Health** will change it's name to **Carelon Medical Benefits Management Inc.** Determine if preapproval is needed for a GA member by clicking the “Medical Policy, Clinical UM Guidelines, and Preapproval Requirements” link on our provider website or by calling the preapproval phone number printed on the back of the member’s ID card. To submit your request for any of the services below, contact AIM online via AIM’s ProviderPortalsm at **<https://guidelines.carelonmedicalbenefitsmanagement.com>** From the drop-down menu, select GA. You may also call AIM toll-free at 866-714-1103, Monday – Friday, 8:00 a.m. – 6:00 p.m. ET.

Carelon Medical Benefits Management Inc. provides benefits management for the programs listed below:

- > **Imaging Level of Care**
- > **Genetic Testing**
- > **Diagnostic Imaging Management**
- > **Cardiovascular Services**
- > **Radiation Therapy Services**
- > **Rehabilitative Services and Site of Care**
- > **Sleep Therapy**
- > **Outpatient Sleep Testing and Therapy Services**
- > **Oncology Drugs**
- > **Cancer Care Quality Program**
- > **Musculoskeletal (MSK) and Site of Care**
- > **Upper Gastrointestinal Endoscopy in Adults, and Site of Care for Certain Surgical Services**

For more details on these programs, please visit the Carelon Medical Benefits Management Inc. site at <https://guidelines.carelonmedicalbenefitsmanagement.com/>  
By clicking on the link above, you will be linked to sites created and/or maintained by another, separate entity (“External Site”). Upon linking you are subject to the terms of use, privacy, copyright and security policies of the External Sites. We provide these links solely for your information and convenience. We encourage you to review the privacy practices of the External Sites.

*\* Date Adopted by -this is the original adoprtion date on the State*

*\*\* Current*

*Version's*

*Implementation Date -this is the effective date of the document that the state is currently usina for reviews*

For more details and information on CUMGs adopted by Anthem Inc., please click below:  
<https://www.anthem.com/provider/policies/>



Health Plan	Funding Type	Year	Criteria / Code	Medical Policy/Clinical Guideline	Medical Policy/Clinical Guideline (MP/CG) Name	Net ROI
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-ANC-04	Ambulance Services: Air and Water	114.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-ANC-07	Inpatient Interfacility Transfers	8.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-BEH-02	Adaptive Behavioral Treatment	20.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-BEH-14	Intensive In-home Behavioral Health Services	9.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-BEH-15	Activity Therapy for Autism Spectrum Disorders and Rett Syndrome	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-06	Compression Devices for Lymphedema	6.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-07	Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output	4.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-31	Powered Wheeled Mobility Devices	10.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-43	High Frequency Chest Compression Devices for Airway Clearance	16.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-44	Electric Tumor Treatment Field (TTF)	89.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-45	Ultrasound Bone Growth Stimulation	8.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-46	Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities in the Home Setting	9.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-DME-49	Standing Frames	12.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	1.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-10	Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability	4.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-11	Genotype Testing for Individual Genetic Polymorphisms to Determine Drug-Metabolizer Status	1.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-13	Genetic Testing for Inherited Diseases	1.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-14	Gene Mutation Testing for Cancer Susceptibility and Management	3.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-15	Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP), Attenuated FAP and MYH-associated polyposis	8.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-16	BRCA Genetic Testing	8.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-18	Genetic Testing for TP53 Mutations	48.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-19	Measurable Residual Disease Assessment in Lymphoid Cancers Using Next Generation Sequencing	1.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-GENE-22	Gene Expression Profiling for Managing Breast Cancer Treatment	7.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-LAB-03	Tropism Testing for HIV Management	(1.0)
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-LAB-13	Skin Nerve Fiber Density Testing	3.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-19	Custodial Care	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-26	Neonatal Levels of Care	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-38	Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-55	Site of Care: Advanced Radiologic Imaging	9.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-59	Upper Gastrointestinal Endoscopy in Adults	4.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-68	Therapeutic Apheresis	20.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-69	Inhaled Nitric Oxide	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	34.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-74	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	19.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-83	Site of Care: Specialty Pharmaceuticals	470.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-89	Home Parenteral Nutrition	25.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-MED-90	Chelation Therapy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-OR-PR-05	Myoelectric Upper Extremity Prosthetic Devices	36.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-REHAB-08	Private Duty Nursing in the Home Setting	194.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-03	Blepharoplasty, Blepharoptosis Repair, and Brow Lift	5.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-08	Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury	42.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-105	Corneal Collagen Cross-Linking	28.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-106	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	30.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-107	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)	6.8

Health Plan	Funding Type	Year	Criteria / Code	Medical Policy/Clinical Guideline	Medical Policy/Clinical Guideline (MP/CG) Name	Net ROI
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-108	Stereotactic Radiofrequency Pallidotomy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-12	Penile Prosthesis Implantation	12.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-18	Septoplasty	6.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS)	9.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-27	Gender Affirming Surgery	8.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-28	Transcatheter Uterine Artery Embolization	19.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	183.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-52	Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services	21.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-61	Cryosurgical, Radiofrequency or Laser Ablation to Treat Solid Tumors Outside the Liver	15.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-63	Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure	21.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-71	Reduction Mammoplasty	27.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-73	Balloon Sinus Ostial Dilation	24.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-75	Transanal Endoscopic Microsurgical (TEM) Excision of Rectal Lesions	34.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-78	Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies	25.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-79	Implantable Infusion Pumps	9.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-81	Cochlear Implants and Auditory Brainstem Implants	56.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-82	Bone-Anchored and Bone Conduction Hearing Aids	22.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	11.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-84	Mandibular/Maxillary (Orthognathic) Surgery	11.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-86	Hip Resurfacing	12.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-88	Mastectomy for Gynecomastia	26.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-89	Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia	37.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-92	Paraesophageal Hernia Repair	38.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-93	Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction	65.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-97	Cardioverter Defibrillators	18.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-SURG-99	Panniculectomy and Abdominoplasty	28.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-TRANS-02	Kidney Transplantation	39.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	CG-TRANS-03	Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation	10.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	ANC.00007	Cosmetic and Reconstructive Services: Skin Related	11.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	ANC.00008	Cosmetic and Reconstructive Services of the Head and Neck	9.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin	32.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00011	Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices	11.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00012	Intrapulmonary Percussive Ventilation Devices	3.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00022	Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)	12.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00030	Altered Auditory Feedback Devices for Fluency Disorders	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00032	Automated External Defibrillators for Home Use	6.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00037	Cooling Devices and Combined Cooling/Heating Devices	21.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00038	Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices	17.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00041	Ultrasonic Diathermy Devices	47.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00042	Electronic Positional Devices for the Treatment of Obstructive Sleep Apnea	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	DME.00043	Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00009	Gene Expression Profiling and Genomic Biomarker Tests for Prostate Cancer	5.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00010	Panel and other Multi-Gene Testing for Polymorphisms to Determine Drug-Metabolizer Status	12.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00016	Gene Expression Profiling for Colorectal Cancer	22.7

Health Plan	Funding Type	Year	Criteria / Code	Medical Policy/Clinical Guideline	Medical Policy/Clinical Guideline (MP/CG) Name	Net ROI
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00018	Gene Expression Profiling for Cancers of Unknown Primary Site	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00023	Gene Expression Profiling of Melanomas and Cutaneous Squamous Cell Carcinoma	4.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00025	Proteogenomic Testing for the Evaluation of Malignancies	5.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00041	Genetic Testing to Confirm the Identity of Laboratory Specimens	2.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00049	Circulating Tumor DNA Panel Testing (Liquid Biopsy)	8.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00050	Gene Expression Profiling for Coronary Artery Disease	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00052	Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	10.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00053	Metagenomic Sequencing for Infectious Disease in the Outpatient Setting	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00054	Paired DNA and Messenger RNA (mRNA) Genetic Testing to Detect, Diagnose and Manage Cancer	9.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00055	Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity	9.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00056	Gene Expression Profiling for Bladder Cancer	8.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00057	Gene Expression Profiling for Idiopathic Pulmonary Fibrosis	0.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	GENE.00059	Hybrid Personalized Molecular Residual Disease Testing for Cancer	9.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00003	In Vitro Chemosensitivity Assays and In Vitro Chemoresistance Assays	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00011	Selected Protein Biomarker Algorithmic Assays	2.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00015	Detection of Circulating Tumor Cells	36.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00019	Proprietary Algorithms for Liver Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00024	Immune Cell Function Assay	0.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00027	Selected Blood, Serum and Cellular Allergy and Toxicity Tests	1.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00029	Rupture of Membranes Testing in Pregnancy	(0.9)
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00030	Measurement of Serum Concentrations of Monoclonal Antibody Drugs and Antibodies to Monoclonal Antibody	0.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00031	Advanced Lipoprotein Testing	(0.9)
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00033	Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer	0.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00034	Serological Antibody Testing For Helicobacter Pylori	(0.9)
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00035	Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis	(0.5)
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00036	Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus	0.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00037	Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00038	Cell-free DNA Testing to Aid in the Monitoring of Kidney Transplants for Rejection	8.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00040	Serum Biomarker Tests for Risk of Preeclampsia	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00041	Machine Learning Derived Probability Score for Rapid Kidney Function Decline	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00045	Selected Tests for the Evaluation and Management of Infertility	4.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00046	Testing for Biochemical Markers for Alzheimer's Disease	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	LAB.00048	Pain Management Biomarker Analysis	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00002	Selected Sleep Testing Services	0.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00004	Technologies for the Evaluation of Skin Lesions (including Dermatoscopy, Epiluminescence Microscopy, Videom	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00011	Sensory Stimulation for Brain-Injured Individuals in Coma or Vegetative State	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00013	Parenteral Antibiotics for the Treatment of Lyme Disease	10.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00024	Adoptive Immunotherapy and Cellular Therapy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00055	Wearable Cardioverter Defibrillators	18.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00057	MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications	(0.8)
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00082	Quantitative Sensory Testing	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00087	Optical Detection for Screening and Identification of Cervical Cancer	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00090	Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders	3.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00092	Automated Nerve Conduction Testing	(1.0)

Health Plan	Funding Type	Year	Criteria / Code	Medical Policy/Clinical Guideline	Medical Policy/Clinical Guideline (MP/CG) Name	Net ROI
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00096	Low-Frequency Ultrasound Therapy for Wound Management	(0.0)
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00098	Hyperoxemic Reperfusion Therapy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00101	Physiologic Recording of Tremor using Accelerometer(s) and Gyroscope(s)	8.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00102	Ultrafiltration in Decompensated Heart Failure	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00103	Automated Evacuation of Meibomian Gland	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00105	Bioimpedance Spectroscopy Devices for the Detection and Management of Lymphedema	(0.6)
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00110	Silver-based Products for Wound and Soft Tissue Applications	1.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00111	Intracardiac Ischemia Monitoring	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00112	Autonomic Testing	0.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00115	Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management	120.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00118	Continuous Monitoring of Intraocular Pressure	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00120	Gene Therapy for Ocular Conditions	26.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00122	Wilderness Programs	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00125	Biofeedback and Neurofeedback	1.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00128	Insulin Potentiation Therapy	2.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00129	Gene Therapy for Spinal Muscular Atrophy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00130	Surface Electromyography Devices for Seizure Monitoring	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00131	Electronic Home Visual Field Monitoring	(1.0)
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00132	Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures	4.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00133	Ingestion Event Monitors	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00137	Eye Movement Analysis Using Non-spatial Calibration for the Diagnosis of Concussion	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00140	Gene Therapy for Beta Thalassemia	45.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	MED.00142	Gene Therapy for Cerebral Adrenoleukodystrophy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	OR-PR.00003	Microprocessor Controlled Lower Limb Prosthesis	21.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	OR-PR.00005	Upper Extremity Myoelectric Orthoses	(1.0)
GA	ASO	Q4_2021 - Q3_2022	Criteria	OR-PR.00006	Powered Robotic Lower Body Exoskeleton Devices	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	OR-PR.00007	Microprocessor Controlled Knee-Ankle-Foot Orthosis	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00034	Dynamic Spinal Visualization (Including Digital Motion X-ray and Cineradiography/ Videofluoroscopy)	(1.0)
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00036	MRI of the Breast	1.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00038	Use of 3-D, 4-D or 5-D Ultrasound in Maternity Care	0.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00053	Cervical and Thoracic Discography	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00057	Near-Infrared Coronary Imaging and Near-Infrared Intravascular Ultrasound Coronary Imaging	0.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00059	Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver	43.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00064	Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	RAD.00065	Radiostereometric Analysis (RSA)	(0.9)
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00005	Partial Left Ventriculectomy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00007	Vagus Nerve Stimulation	199.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00008	Mechanized Spinal Distraction Therapy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00010	Treatments for Urinary Incontinence	9.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00011	Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue	29.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00019	Transmyocardial Revascularization	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00023	Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures	17.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00026	Deep Brain, Cortical, and Cerebellar Stimulation	81.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00032	Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention	24.7

Health Plan	Funding Type	Year	Criteria / Code	Medical Policy/Clinical Guideline	Medical Policy/Clinical Guideline (MP/CG) Name	Net ROI
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00036	Fetal Surgery for Prenatally Diagnosed Malformations	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00037	Treatment of Varicose Veins (Lower Extremities)	12.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00043	Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons	19.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00045	Extracorporeal Shock Wave Therapy	8.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00047	Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis	16.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00052	Percutaneous Vertebral Disc and Vertebral Endplate Procedures	12.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00053	Unicondylar Interpositional Spacer	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00061	Presbyopia and Astigmatism-Correcting Intraocular Lenses	6.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00062	Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele	87.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00071	Percutaneous and Endoscopic Spinal Surgery	24.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00072	Lysis of Epidural Adhesions	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00073	Epiduroscopy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00075	Intervertebral Stabilization Devices	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00076	Nerve Graft after Prostatectomy	1.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00077	Uterine Fibroid Ablation: Laparoscopic, Percutaneous or Transcervical Image Guided Techniques	21.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00079	Nasal Valve Repair	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00084	Implantable Middle Ear Hearing Aids	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00088	Coblation? Therapies for Musculoskeletal Conditions	22.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00092	Implanted Devices for Spinal Stenosis	54.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00095	Viscocalanostomy and Canaloplasty	6.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00096	Surgical and Ablative Treatments for Chronic Headaches	4.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00097	Scoliosis Surgery	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00100	Cryoablation for Plantar Fasciitis and Plantar Fibroma	(0.4)
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00102	Artificial Anal Sphincter for the Treatment of Severe Fecal Incontinence	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	11.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00104	Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis	27.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00105	Bicompartmental Knee Arthroplasty	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00107	Prostate Saturation Biopsy	32.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00111	Axial Lumbar Interbody Fusion	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00112	Implantation of Occipital, Supraorbital or Trigeminal Nerve Stimulation Devices (and Related Procedures)	46.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00113	Artificial Retinal Devices	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00114	Facet Joint Allograft Implants for Facet Disease	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00116	High Resolution Anoscopy Screening for Anal Intraepithelial Neoplasia (AIN) and Squamous Cell Cancer of the A	(0.6)
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00118	Bronchial Thermoplasty	49.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00119	Endobronchial Valve Devices	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00120	Internal Rib Fixation Systems	5.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00121	Transcatheter Heart Valve Procedures	19.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00123	Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects	3.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00124	Carotid Sinus Baroreceptor Stimulation Devices	(1.0)
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00126	Irreversible Electroporation	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00128	Implantable Left Atrial Hemodynamic Monitor	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00129	Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring	109.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00130	Annulus Closure After Discectomy	179.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00131	Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GER	13.3



Health Plan	Funding Type	Year	Criteria / Code	Medical Policy/Clinical Guideline	Medical Policy/Clinical Guideline (MP/CG) Name	Net ROI
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00132	Drug-Eluting Devices for Maintaining Sinus Ostial Patency	10.2
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00134	Interspinous Process Fixation Devices	360.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00135	Radiofrequency Ablation of the Renal Sympathetic Nerves	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00139	Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery with Radiofrequency Spectros	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00140	Peripheral Nerve Blocks for Treatment of Neuropathic Pain	6.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00141	Doppler-Guided Transanal Hemorrhoidal Dearterialization	6.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00142	Genicular Nerve Blocks and Ablation for Chronic Knee Pain	4.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00144	Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia	6.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and A	0.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00146	Extracorporeal Carbon Dioxide Removal	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00150	Leadless Pacemaker	103.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00151	Balloon Dilation of the Eustachian Tubes	26.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00152	Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00153	Cardiac Contractility Modulation Therapy	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00156	Implanted Artificial Iris Devices	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00157	Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis	15.3
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00158	Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain	33.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00159	Focal Laser Ablation for the Treatment of Prostate Cancer	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	SURG.00160	Implanted Port Delivery Systems to Treat Ocular Disease	(0.3)
GA	ASO	Q4_2021 - Q3_2022	Criteria	THER-RAD.000	Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation	22.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00004	Cell Transplantation (Mesencephalic, Adrenal-Brain and Fetal Xenograft)	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00008	Liver Transplantation	114.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00009	Lung and Lobar Transplantation	65.5
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00010	Autologous and Allogeneic Pancreatic Islet Cell Transplantation	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00011	Pancreas Transplantation and Pancreas Kidney Transplantation	35.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00013	Small Bowel, Small Bowel/Liver and Multivisceral Transplantation	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00016	Umbilical Cord Blood Progenitor Cell Collection, Storage and Transplantation	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00023	Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias	60.7
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	336.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00025	Laboratory Testing as an Aid in the Diagnosis of Heart Transplant Rejection	11.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00026	Heart/Lung Transplantation	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00027	Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors	84.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00028	Hematopoietic Stem Cell Transplantation for Hodgkin Disease and non-Hodgkin Lymphoma	284.8
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00029	Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias	1.1
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00030	Hematopoietic Stem Cell Transplantation for Germ Cell Tumors	62.6
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00031	Hematopoietic Stem Cell Transplantation for Autoimmune Disease and Miscellaneous Solid Tumors	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00033	Heart Transplantation	66.4
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00034	Hematopoietic Stem Cell Transplantation for Diabetes Mellitus	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00035	Therapeutic use of Stem Cells, Blood and Bone Marrow Products	2.9
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00037	Uterine Transplantation	0.0
GA	ASO	Q4_2021 - Q3_2022	Criteria	TRANS.00038	Thymus Tissue Transplantation	0.0

**EXHIBIT 6**  
**PRIOR AUTHORIZATION**  
**GEORGIA – SELF FUNDED GROUP (ASO) –LOCAL COMMERCIAL**

**Inpatient, In-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	1960	436	81%
Group MH/SUD	51	4	92%

**Inpatient, Out-of-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	158	46	77%
Group MH/SUD	13	4	76%

**Outpatient, In-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	95984	2061	97%
Group MH/SUD	1589	49	97%

**Outpatient, Out-of-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	24331	437	98%
Group MH/SUD	543	52	91%*

Note: Data is for self-funded plans whose plans are headquartered in Georgia without regard to where the members of the plan reside (e.g., group is headquartered in GA but members may live in-or-outside of Georgia). Data includes requests for precertification as well (i.e., services that are not on the prior authorization list). It also includes requests to see an out-of-network provider.

Report run on or around February 27, 2023 by Tina Jones, Business Info Developer Consultant, Sr.

\* Upon review, the MH/SUD requests for outpatient, out of network services are overall substantially lower than M/S. In the group market, 9 of the 52 denials were due to a network provider being available to serve members and 8 denials based on a non-covered benefit. The remaining denials were based on medical necessity reasons.





## NQTL SELF COMPLIANCE TOOL

### 1. Identify the NQTL: Participating Provider Fee Schedule Rates (Georgia)

*Overview:* This nonquantitative treatment limitation analysis focuses on how Anthem decides the amount to pay network providers for the services they provide to our members.

### 2. Identify the factors considered in the design of the NQTL:

- Product (e.g., PPO, HMO, indemnity, etc.)
- Provider location – Atlanta and non-Atlanta
- Provider setting - office or facility
- State statute or regulation that dictates how we pay a provider (e.g., telehealth, etc.)
- Competitiveness of our rates (e.g., are providers of a particular type willing to contract with us at the standard rate; feedback from providers that our rates are too low/high, etc.)
- The CPT/HCPCS Code being billed
- Medicare reimbursement
- Education and licensure level of provider
- Frequency with which a provider type bills a small set of specific CPT codes almost exclusively (e.g., PCPs bill E&M codes) whereby establishing a separate fee schedule for that provider type is appropriate to provide adequate and competitive reimbursement (i.e., PCP, PT/OT/ST, Podiatrist)
- For new CPT codes, evaluation of whether it is a replacement of a prior code, which we would crosswalk to the prior CPT reimbursement amount, or a new CPT code. If we determine it is a new code, fees are set based on relativity to surrounding CPT codes.

The following factors are considered when reviewing and making changes to the fee schedule rates:

- Compliance with State & Federal network adequacy laws and regulations
- Ability to attract and maintain providers in our network
- Optimize medical spend
- Fluctuations in CMS physician fee schedule rates

Anthem does not assign more weight to any one of the factors in either areas identified above.

### 3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Sources:

Centers for Medicare & Medicaid Services Fee Schedules  
Applicable State Statutes, Regulations or Guidance  
Provider feedback and willingness to contract  
CPT and HCPCS Codes

Process:

GA has separate base fee schedules:



- PPO
- Facility urban, PPO non-facility urban, PPO facility rural, PPO non-facility rural
- HMO Facility urban, HMO non-facility urban, HMO facility rural, HMO non-facility rural
- Traditional Facility urban, Traditional non-facility urban, Traditional facility rural, Traditional non-facility rural
- PCP Facility urban, PCP non-facility urban, PCP facility rural, PCP non-facility rural
- PT/OT/ST Facility urban, PT/OT/ST non-facility urban, PT/OT/ST facility rural, PT/OT/ST non-facility rural
- Chiropractic Facility urban, Chiropractic non-facility urban, Chiropractic facility rural, Chiropractic non-facility rural
- Podiatrist Facility urban, Podiatrist non-facility urban, Podiatrist facility rural, Podiatrist non-facility rural
- Statewide BH Fee Schedule

For the PCP, PT/OT/ST, Chiropractic and Podiatrist fee schedules, only certain CPT codes are contained on those schedules. If a provider were to bill a code not on that fee schedule, then the fee schedule for the applicable product type (PPO, HMO, Traditional) would apply. Except where we individually negotiate, (e.g. Hospital group), all other providers are paid solely based on the PPO, HMO or Traditional fee schedules.

Non-MD providers are paid at a percentage of the applicable fee schedule rate, based on their level of education, licensure level and how Medicare or Medicaid pays them, as follows:

Mid-level	Percentage of MD rate
0042 - Nurse Practitioner	85%
0334 - Physician Assistants	85%
0041 - Certified Nurse Midwife	85%
0080 - Psychologist	80%
0004- Social Worker	66%
0356- LMFT	66%
0111- Counselor	66%
0374 - Board Certified Behavior Analyst	66%

Historically a work group meets to review reimbursement rates under the various fee schedules. The work group consists of Director of Network Management, Cost of Care Analyst, Health Economics, and Pricing and Configuration. The team does the initial review of data and makes the recommendation to the RVP of Provider Solutions.

Data used to review rates is the most current twelve months of utilization. Review occurs at the type of service, specialty, and geographic locations.



All changes recommended by the team are reviewed by the reimbursement committee prior to implementation. Letters are mailed giving the required 90 days' advance written notice to impacted contracted providers. Directions to review the fee schedule samples are provided in the letter.

Future State: Georgia has a new RVP; new strategy/process will be developed for the 2022 update.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Yes, we apply the same process uniformly to create the rates based on the CPT/HCPCS Codes being billed. All professional providers with whom we directly contract (i.e., providers who are not part of a hospital system or other large grouping of providers) are offered the same rates, with the exception of midlevel providers.

For the comparative analysis, these were the rates in effect, when the Provider Network Management Director pulled the data on April 26, 2021. The Director of Provider Economics ran second report on May 7, 2021. The list below reflects the reimbursement amounts for the evaluation and management codes comparing family practice MD and a psychiatrist. Overall payment is comparable between family practice MD and a psychiatrist. Some evaluation and management codes are paid higher for psychiatrist and some are paid higher for family practice MD.

#### Comparative Analysis

Specialty	Code	Description	Office
PSYCHIATRY - MD/DO	99202	Office/outpatient visit new	\$76.38
FAMILY PRACTICE	99202	Office/outpatient visit new	\$76.13
PSYCHIATRY - MD/DO	99203	Office/outpatient visit new	\$113.35
FAMILY PRACTICE	99203	Office/outpatient visit new	\$110.02
PSYCHIATRY - MD/DO	99204	Office/outpatient visit new	\$159.95
FAMILY PRACTICE	99204	Office/outpatient visit new	\$168.49
PSYCHIATRY - MD/DO	99205	Office/outpatient visit new	\$202.90
FAMILY PRACTICE	99205	Office/outpatient visit new	\$212.41
PSYCHIATRY - MD/DO	99211	Office/outpatient visit est	\$25.49
FAMILY PRACTICE	99211	Office/outpatient visit est	\$21.55
PSYCHIATRY - MD/DO	99212	Office/outpatient visit est	\$44.81
FAMILY PRACTICE	99212	Office/outpatient visit est	\$44.29
PSYCHIATRY - MD/DO	99213	Office/outpatient visit est	\$62.40
FAMILY PRACTICE	99213	Office/outpatient visit est	\$74.14
PSYCHIATRY - MD/DO	99214	Office/outpatient visit est	\$97.30
FAMILY PRACTICE	99214	Office/outpatient visit est	\$109.59
PSYCHIATRY - MD/DO	99215	Office/outpatient visit est	\$140.65
FAMILY PRACTICE	99215	Office/outpatient visit est	\$148.17



5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. MHPAEA does not require plans to pay the same reimbursement rates for medical/surgical and MH/SUD services. MHPAEA does not mandate equality of outcomes. *See, e.g., James C. v. Anthem Blue Cross Blue Shield*, 2021 U.S. Dist. LEXIS 115701, \*59 (D. Utah June 21, 2021). This principle applies to reimbursement rates. “MHPAEA does not require a plan or issuer to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers[.]” 2019 FAQs, Q6., at 10. In order to determine whether a plan complies with the NQTL requirements under MHPAEA, one must examine whether “the [plan’s] methodology for developing and applying reimbursement rates under the plan is comparable and applied no more stringently for MH/SUD benefits when compared to the methodology for developing and applying reimbursement rates for medical/surgical benefits under the plan.” *Id.* at 9.

Anthem’s strategy with respect to setting reimbursement rates is the same for both medical/surgical and MH/SUD services – set reimbursement rates high enough to guarantee an adequate network, but not so high that they negatively impact Anthem’s members and unnecessarily increase the cost of care. Anthem uses a comparable process for setting reimbursement rates for medical/surgical and MH/SUD services.

GA Spec	Specialty	CPT Code	Non Facility (Office) Place of Service			Facility Place of Service			SPECID
			Standard GA	2023 Medicare Rate for GA Locality 1	Standard GA Rate as a Percentage of GA Locality 1 Medicare	Standard GA	2023 Medicare Rate for GA Locality 1	Standard GA Rate as a Percentage of GA Locality 1 Medicare	
SPEC	Orthopedic Surgery	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Orthopedic Surgery	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Cardiologists	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Cardiologists	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
PCP	Internists MD	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
PCP	Internists MD	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Endocrinologists	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Endocrinologists	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Gastroenterologist	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Gastroenterologist	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Neurologists	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Neurologists	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
PCP	Pediatrician	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
PCP	Pediatrician	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Dermatologists	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Dermatologists	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
BH	Psychiatrists	99203	\$113.35	\$112.83	100.5%	\$83.79	\$83.07	100.9%	SPEC6104
BH	Psychiatrists	99213	\$62.40	\$90.79	68.7%	\$41.49	\$66.10	62.8%	SPEC6104
BH	Psychologists *	90832	\$54.31	\$75.56	71.9%	\$54.31	\$66.43	81.8%	SPEC6300
BH	Psychologists *	90834	\$78.75	\$99.96	78.8%	\$78.75	\$88.12	89.4%	SPEC6300
BH	Psychologists *	90837	\$116.53	\$147.05	79.2%	\$116.53	\$129.46	90.0%	SPEC6300
BH	Psychologists *	90791	\$138.28	\$174.83	79.1%	\$138.28	\$150.82	91.7%	SPEC6300
Mid-levels	LCSW *	90832	\$61.70	\$75.56	81.7%	\$48.14	\$66.43	72.5%	SPEC4427
Mid-levels	LCSW *	90834	\$79.33	\$99.96	79.4%	\$72.22	\$88.12	82.0%	SPEC4427
Mid-levels	LCSW *	90837	\$116.11	\$147.05	79.0%	\$108.99	\$129.46	84.2%	SPEC4427
Mid-levels	LCSW *	90791	\$148.65	\$174.83	85.0%	\$115.11	\$150.82	76.3%	SPEC4427
SPEC	Podiatrists *	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Podiatrists *	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Chiropractor	99203	\$116.61	\$112.83	103.4%	\$83.14	\$83.07	100.1%	SPEC4403
SPEC	Chiropractor	99213	\$78.65	\$90.79	86.6%	\$55.45	\$66.10	83.9%	SPEC4403
SPEC	Occupational Therapy *	97165	\$92.45	\$101.59	91.0%	\$92.45	\$101.59	91.0%	SPEC4403
SPEC	Occupational Therapy *	97166	\$92.45	\$101.59	91.0%	\$92.45	\$101.59	91.0%	SPEC4403
SPEC	Occupational Therapy *	97167	\$92.45	\$101.59	91.0%	\$92.45	\$101.59	91.0%	SPEC4403
SPEC	Occupational Therapy *	97168	\$62.94	\$70.10	89.8%	\$62.94	\$70.10	89.8%	SPEC4403
SPEC	Physical Therapy *	97161	\$85.63	\$101.59	84.3%	\$85.63	\$101.59	84.3%	SPEC4403
SPEC	Physical Therapy *	97162	\$85.63	\$101.59	84.3%	\$85.63	\$101.59	84.3%	SPEC4403
SPEC	Physical Therapy *	97163	\$85.63	\$101.59	84.3%	\$85.63	\$101.59	84.3%	SPEC4403
SPEC	Physical Therapy *	97164	\$57.91	\$70.43	82.2%	\$57.91	\$70.43	82.2%	SPEC4403
	Speech Therapy	N/A							

GA Spec	Specialty	CPT Code	Non Facility (Office) Place of Service			Facility Place of Service			SPECID
			Standard GA	2023 Medicare Rate for GA Locality 99	Standard GA Rate as a Percentage of GA Locality 99 Medicare	Standard GA	2023 Medicare Rate for GA Locality 99	Standard GA Rate as a Percentage of GA Locality 99 Medicare	
SPEC	Orthopedic Surgery	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Orthopedic Surgery	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
SPEC	Cardiologists	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Cardiologists	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
PCP	Internists MD	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4401
PCP	Internists MD	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4401
SPEC	Endocrinologists	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Endocrinologists	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
SPEC	Gastroenterologist	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Gastroenterologist	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
SPEC	Neurologists	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Neurologists	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
PCP	Pediatrician	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4401
PCP	Pediatrician	99213	\$74.14	\$85.71	86.5%	\$74.14	\$63.91	116.0%	SPEC4401
SPEC	Dermatologists	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Dermatologists	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
BH	Psychiatrists	99203	\$113.35	\$106.64	106.3%	\$83.79	\$80.37	104.3%	SPEC6104
BH	Psychiatrists	99213	\$62.40	\$85.71	72.8%	\$41.49	\$63.91	64.9%	SPEC6104
BH	Psychologists *	90832	\$54.31	\$73.61	73.8%	\$54.31	\$65.55	82.9%	SPEC6300
BH	Psychologists *	90834	\$78.75	\$97.38	80.9%	\$78.75	\$86.93	90.6%	SPEC6300
BH	Psychologists *	90837	\$116.53	\$143.28	81.3%	\$116.53	\$127.76	91.2%	SPEC6300
BH	Psychologists *	90791	\$138.28	\$169.99	81.3%	\$138.28	\$148.79	92.9%	SPEC6300
Mid-levels	LCSW *	90832	\$59.28	\$73.61	80.5%	\$46.25	\$65.55	70.6%	SPEC4426
Mid-levels	LCSW *	90834	\$76.23	\$97.38	78.3%	\$69.39	\$86.93	79.8%	SPEC4426
Mid-levels	LCSW *	90837	\$111.56	\$143.28	77.9%	\$104.73	\$127.76	82.0%	SPEC4426
Mid-levels	LCSW *	90791	\$142.84	\$169.99	84.0%	\$110.60	\$148.79	74.3%	SPEC4426
SPEC	Podiatrists *	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Podiatrists *	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
SPEC	Chiropractor	99203	\$110.02	\$106.64	103.2%	\$79.83	\$80.37	99.3%	SPEC4402
SPEC	Chiropractor	99213	\$74.14	\$85.71	86.5%	\$53.20	\$63.91	83.2%	SPEC4402
SPEC	Occupational Therapy *	97165	\$86.99	\$95.96	90.7%	\$86.99	\$95.96	90.7%	SPEC4402
SPEC	Occupational Therapy *	97166	\$86.99	\$95.96	90.7%	\$86.99	\$95.96	90.7%	SPEC4402
SPEC	Occupational Therapy *	97167	\$86.99	\$95.96	90.7%	\$86.99	\$95.96	90.7%	SPEC4402
SPEC	Occupational Therapy *	97168	\$59.01	\$65.85	89.6%	\$59.01	\$65.85	89.6%	SPEC4402
SPEC	Physical Therapy *	97161	\$80.84	\$95.96	84.2%	\$80.84	\$95.96	84.2%	SPEC4402
SPEC	Physical Therapy *	97162	\$80.84	\$95.96	84.2%	\$80.84	\$95.96	84.2%	SPEC4402
SPEC	Physical Therapy *	97163	\$80.84	\$95.96	84.2%	\$80.84	\$95.96	84.2%	SPEC4402
SPEC	Physical Therapy *	97164	\$54.48	\$66.15	82.4%	\$54.48	\$66.15	82.4%	SPEC4402
	Speech Therapy	N/A							

GA Spec	Specialty	CPT Code	Non Facility (Office) Place of Service			Facility Place of Service			SPECID
			Standard GA	2023 Medicare Rate for GA Locality 1	Standard GA Rate as a Percentage of GA Locality 1 Medicare	Standard GA	2023 Medicare Rate for GA Locality 1	Standard GA Rate as a Percentage of GA Locality 1 Medicare	
SPEC	Orthopedic Surgery	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Orthopedic Surgery	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Cardiologists	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Cardiologists	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
PCP	Internists MD	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
PCP	Internists MD	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Endocrinologists	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Endocrinologists	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Gastroenterologist	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Gastroenterologist	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Neurologists	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Neurologists	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
PCP	Pediatrician	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
PCP	Pediatrician	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Dermatologists	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Dermatologists	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
BH	Psychiatrists	99203	\$113.35	\$112.83	100.5%	\$83.79	\$83.07	100.9%	SPEC6104
BH	Psychiatrists	99213	\$62.40	\$90.79	68.7%	\$41.49	\$66.10	62.8%	SPEC6104
BH	Psychologists *	90832	\$54.31	\$75.56	71.9%	\$54.31	\$66.43	81.8%	SPEC6300
BH	Psychologists *	90834	\$78.75	\$99.96	78.8%	\$78.75	\$88.12	89.4%	SPEC6300
BH	Psychologists *	90837	\$116.53	\$147.05	79.2%	\$116.53	\$129.46	90.0%	SPEC6300
BH	Psychologists *	90791	\$138.28	\$174.83	79.1%	\$138.28	\$150.82	91.7%	SPEC6300
Mid-levels	LCSW *	90832	\$64.32	\$75.56	85.1%	\$50.19	\$66.43	75.6%	SPEC2826
Mid-levels	LCSW *	90834	\$82.71	\$99.96	82.7%	\$75.29	\$88.12	85.4%	SPEC2826
Mid-levels	LCSW *	90837	\$121.05	\$147.05	82.3%	\$113.63	\$129.46	87.8%	SPEC2826
Mid-levels	LCSW *	90791	\$154.98	\$174.83	88.6%	\$120.00	\$150.82	79.6%	SPEC2826
SPEC	Podiatrists *	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Podiatrists *	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Chiropractor	99203	\$123.76	\$112.83	109.7%	\$88.23	\$83.07	106.2%	SPEC2842
SPEC	Chiropractor	99213	\$83.48	\$90.79	91.9%	\$58.85	\$66.10	89.0%	SPEC2842
SPEC	Occupational Therapy *	97165	\$92.45	\$101.59	91.0%	\$92.45	\$101.59	91.0%	SPEC2842
SPEC	Occupational Therapy *	97166	\$92.45	\$101.59	91.0%	\$92.45	\$101.59	91.0%	SPEC2842
SPEC	Occupational Therapy *	97167	\$92.45	\$101.59	91.0%	\$92.45	\$101.59	91.0%	SPEC2842
SPEC	Occupational Therapy *	97168	\$62.94	\$70.10	89.8%	\$62.94	\$70.10	89.8%	SPEC2842
SPEC	Physical Therapy *	97161	\$85.63	\$101.59	84.3%	\$85.63	\$101.59	84.3%	SPEC2842
SPEC	Physical Therapy *	97162	\$85.63	\$101.59	84.3%	\$85.63	\$101.59	84.3%	SPEC2842
SPEC	Physical Therapy *	97163	\$85.63	\$101.59	84.3%	\$85.63	\$101.59	84.3%	SPEC2842
SPEC	Physical Therapy *	97164	\$57.91	\$70.43	82.2%	\$57.91	\$70.43	82.2%	SPEC2842
	Speech Therapy	N/A							



GA Spec	Specialty	CPT Code	Non Facility (Office) Place of Service			Facility Place of Service			SPECID
			Standard GA	2023 Medicare Rate for GA Locality 99	Standard GA Rate as a Percentage of GA Locality 99 Medicare	Standard GA	2023 Medicare Rate for GA Locality 99	Standard GA Rate as a Percentage of GA Locality 99 Medicare	
SPEC	Orthopedic Surgery	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Orthopedic Surgery	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
SPEC	Cardiologists	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Cardiologists	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
PCP	Internists MD	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2841
PCP	Internists MD	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2841
SPEC	Endocrinologists	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Endocrinologists	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
SPEC	Gastroenterologist	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Gastroenterologist	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
SPEC	Neurologists	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Neurologists	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
PCP	Pediatrician	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2841
PCP	Pediatrician	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2841
SPEC	Dermatologists	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Dermatologists	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
BH	Psychiatrists	99203	\$113.35	\$106.64	106.3%	\$83.79	\$80.37	104.3%	SPEC6104
BH	Psychiatrists	99213	\$62.40	\$85.71	72.8%	\$41.49	\$63.91	64.9%	SPEC6104
BH	Psychologists *	90832	\$54.31	\$73.61	73.8%	\$54.31	\$65.55	82.9%	SPEC6300
BH	Psychologists *	90834	\$78.75	\$97.38	80.9%	\$78.75	\$86.93	90.6%	SPEC6300
BH	Psychologists *	90837	\$116.53	\$143.28	81.3%	\$116.53	\$127.76	91.2%	SPEC6300
BH	Psychologists *	90791	\$138.28	\$169.99	81.3%	\$138.28	\$148.79	92.9%	SPEC6300
Mid-levels	LCSW *	90832	\$78.85	\$73.61	107.1%	\$61.52	\$65.55	92.9%	SPEC2827
Mid-levels	LCSW *	90834	\$101.38	\$97.38	104.1%	\$92.29	\$86.93	106.2%	SPEC2827
Mid-levels	LCSW *	90837	\$148.38	\$143.28	103.6%	\$139.29	\$127.76	109.0%	SPEC2827
Mid-levels	LCSW *	90791	\$189.97	\$169.99	111.8%	\$147.10	\$148.79	98.9%	SPEC2827
SPEC	Podiatrists *	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Podiatrists *	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
SPEC	Chiropractor	99203	\$116.76	\$106.64	109.5%	\$84.72	\$80.37	105.4%	SPEC2843
SPEC	Chiropractor	99213	\$78.68	\$85.71	91.8%	\$56.46	\$63.91	88.3%	SPEC2843
SPEC	Occupational Therapy *	97165	\$86.99	\$95.96	90.7%	\$86.99	\$95.96	90.7%	SPEC2843
SPEC	Occupational Therapy *	97166	\$86.99	\$95.96	90.7%	\$86.99	\$95.96	90.7%	SPEC2843
SPEC	Occupational Therapy *	97167	\$86.99	\$95.96	90.7%	\$86.99	\$95.96	90.7%	SPEC2843
SPEC	Occupational Therapy *	97168	\$59.01	\$65.85	89.6%	\$59.01	\$65.85	89.6%	SPEC2843
SPEC	Physical Therapy *	97161	\$80.84	\$95.96	84.2%	\$80.84	\$95.96	84.2%	SPEC2843
SPEC	Physical Therapy *	97162	\$80.84	\$95.96	84.2%	\$80.84	\$95.96	84.2%	SPEC2843
SPEC	Physical Therapy *	97163	\$80.84	\$95.96	84.2%	\$80.84	\$95.96	84.2%	SPEC2843
SPEC	Physical Therapy *	97164	\$54.48	\$66.15	82.4%	\$54.48	\$66.15	82.4%	SPEC2843
	Speech Therapy	N/A							

this is the rate for specialists, there is a different SPEC2825 for PCPs  
this is the rate for specialists, there is a different SPEC2825 for PCPs  
this is the rate for specialists, there is a different SPEC2825 for PCPs  
this is the rate for specialists, there is a different SPEC2825 for PCPs

GA Spec	Specialty	CPT Code	Non Facility (Office) Place of Service			Facility Place of Service			SPECID
			Standard GA	2023 Medicare Rate for GA Locality 1	Standard GA Rate as a Percentage of GA Locality 1 Medicare	Standard GA	2023 Medicare Rate for GA Locality 1	Standard GA Rate as a Percentage of GA Locality 1 Medicare	
SPEC	Orthopedic Surgery	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Orthopedic Surgery	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Cardiologists	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Cardiologists	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
PCP	Internists MD	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
PCP	Internists MD	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Endocrinologists	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Endocrinologists	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Gastroenterologist	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Gastroenterologist	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Neurologists	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Neurologists	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
PCP	Pediatrician	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
PCP	Pediatrician	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Dermatologists	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Dermatologists	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
BH	Psychiatrists	99203	\$113.35	\$112.83	100.5%	\$83.79	\$83.07	100.9%	SPEC6104
BH	Psychiatrists	99213	\$62.40	\$90.79	68.7%	\$41.49	\$66.10	62.8%	SPEC6104
BH	Psychologists *	90832	\$54.31	\$75.56	71.9%	\$54.31	\$66.43	81.8%	SPEC6300
BH	Psychologists *	90834	\$78.75	\$99.96	78.8%	\$78.75	\$88.12	89.4%	SPEC6300
BH	Psychologists *	90837	\$116.53	\$147.05	79.2%	\$116.53	\$129.46	90.0%	SPEC6300
BH	Psychologists *	90791	\$138.28	\$174.83	79.1%	\$138.28	\$150.82	91.7%	SPEC6300
Mid-levels	LCSW *	90832	\$75.56	\$75.56	100.0%	\$66.43	\$66.43	100.0%	SPEC8001
Mid-levels	LCSW *	90834	\$99.96	\$99.96	100.0%	\$88.12	\$88.12	100.0%	SPEC8001
Mid-levels	LCSW *	90837	\$147.05	\$147.05	100.0%	\$129.46	\$129.46	100.0%	SPEC8001
Mid-levels	LCSW *	90791	\$174.83	\$174.83	100.0%	\$150.82	\$150.82	100.0%	SPEC8001
SPEC	Podiatrists *	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Podiatrists *	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Chiropractor	99203	\$112.83	\$112.83	100.0%	\$83.07	\$83.07	100.0%	SPEC8001
SPEC	Chiropractor	99213	\$90.79	\$90.79	100.0%	\$66.10	\$66.10	100.0%	SPEC8001
SPEC	Occupational Therapy *	97165	\$101.59	\$101.59	100.0%	\$101.59	\$101.59	100.0%	SPEC8001
SPEC	Occupational Therapy *	97166	\$101.59	\$101.59	100.0%	\$101.59	\$101.59	100.0%	SPEC8001
SPEC	Occupational Therapy *	97167	\$101.59	\$101.59	100.0%	\$101.59	\$101.59	100.0%	SPEC8001
SPEC	Occupational Therapy *	97168	\$70.10	\$70.10	100.0%	\$70.10	\$70.10	100.0%	SPEC8001
SPEC	Physical Therapy *	97161	\$101.59	\$101.59	100.0%	\$101.59	\$101.59	100.0%	SPEC8001
SPEC	Physical Therapy *	97162	\$101.59	\$101.59	100.0%	\$101.59	\$101.59	100.0%	SPEC8001
SPEC	Physical Therapy *	97163	\$101.59	\$101.59	100.0%	\$101.59	\$101.59	100.0%	SPEC8001
SPEC	Physical Therapy *	97164	\$70.43	\$70.43	100.0%	\$70.43	\$70.43	100.0%	SPEC8001
	Speech Therapy	N/A							

GA Spec	Specialty	CPT Code	Non Facility (Office) Place of Service			Facility Place of Service			SPECID
			Standard GA	2023 Medicare Rate for GA Locality 99	Standard GA Rate as a Percentage of GA Locality 99 Medicare	Standard GA	2023 Medicare Rate for GA Locality 99	Standard GA Rate as a Percentage of GA Locality 99 Medicare	
SPEC	Orthopedic Surgery	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Orthopedic Surgery	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Cardiologists	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Cardiologists	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
PCP	Internists MD	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
PCP	Internists MD	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Endocrinologists	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Endocrinologists	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Gastroenterologist	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Gastroenterologist	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Neurologists	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Neurologists	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
PCP	Pediatrician	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
PCP	Pediatrician	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Dermatologists	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Dermatologists	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
BH	Psychiatrists	99203	\$113.35	\$106.64	106.3%	\$83.79	\$80.37	104.3%	SPEC6104
BH	Psychiatrists	99213	\$62.40	\$85.71	72.8%	\$41.49	\$63.91	64.9%	SPEC6104
BH	Psychologists *	90832	\$54.31	\$73.61	73.8%	\$54.31	\$65.55	82.9%	SPEC6300
BH	Psychologists *	90834	\$78.75	\$97.38	80.9%	\$78.75	\$86.93	90.6%	SPEC6300
BH	Psychologists *	90837	\$116.53	\$143.28	81.3%	\$116.53	\$127.76	91.2%	SPEC6300
BH	Psychologists *	90791	\$138.28	\$169.99	81.3%	\$138.28	\$148.79	92.9%	SPEC6300
Mid-levels	LCSW *	90832	\$75.56	\$73.61	102.6%	\$66.43	\$65.55	101.3%	SPEC8010
Mid-levels	LCSW *	90834	\$99.96	\$97.38	102.6%	\$88.12	\$86.93	101.4%	SPEC8010
Mid-levels	LCSW *	90837	\$147.05	\$143.28	102.6%	\$129.46	\$127.76	101.3%	SPEC8010
Mid-levels	LCSW *	90791	\$174.83	\$169.99	102.8%	\$150.82	\$148.79	101.4%	SPEC8010
SPEC	Podiatrists *	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Podiatrists *	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Chiropractor	99203	\$112.83	\$106.64	105.8%	\$83.07	\$80.37	103.4%	SPEC8010
SPEC	Chiropractor	99213	\$90.79	\$85.71	105.9%	\$66.10	\$63.91	103.4%	SPEC8010
SPEC	Occupational Therapy *	97165	\$101.59	\$95.96	105.9%	\$101.59	\$95.96	105.9%	SPEC8010
SPEC	Occupational Therapy *	97166	\$101.59	\$95.96	105.9%	\$101.59	\$95.96	105.9%	SPEC8010
SPEC	Occupational Therapy *	97167	\$101.59	\$95.96	105.9%	\$101.59	\$95.96	105.9%	SPEC8010
SPEC	Occupational Therapy *	97168	\$70.10	\$65.85	106.5%	\$70.10	\$65.85	106.5%	SPEC8010
SPEC	Physical Therapy *	97161	\$101.59	\$95.96	105.9%	\$101.59	\$95.96	105.9%	SPEC8010
SPEC	Physical Therapy *	97162	\$101.59	\$95.96	105.9%	\$101.59	\$95.96	105.9%	SPEC8010
SPEC	Physical Therapy *	97163	\$101.59	\$95.96	105.9%	\$101.59	\$95.96	105.9%	SPEC8010
SPEC	Physical Therapy *	97164	\$70.43	\$66.15	106.5%	\$70.43	\$66.15	106.5%	SPEC8010
	Speech Therapy	N/A							



## **NQTL SELF COMPLIANCE TOOL POST SERVICE REVIEWS**

1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply.

Anthem's fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary. The plan document example is attached as Exhibit 1 and details how the post service review process works for members. Post service review is defined in the plan documents as: "A medical necessity review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided and the claim submitted to Anthem. Post-service reviews are performed when a service, treatment or admission did not need Precertification. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us." Providers are informed of this process in the "Utilization Management" section of the Provider Manual.

This analysis explains when Anthem performs a post-service review and how Anthem's processes, strategies, evidentiary standards and other factors for post-service reviews comply with the NQTL requirements under MHPAEA.

Post service reviews applies to medical/surgical and mental health/substance use disorder services in the inpatient (in-network, out of network) and outpatient (in-network, out of network) benefit classifications.

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:
  - a. Does Anthem have a medical policy or clinical utilization management (UM) guideline or third-party guideline?
  - b. Was a prior authorization required?

Anthem does not assign more weight to any one of the factors in either area identified above. However, if a medical policy or clinical UM guideline does not exist, retrospective review will not be conducted.

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:



**Presence of a Medical Policy or Clinical Utilization Management (UM) Guideline:** The Medical Policy and Clinical Utilization Management (UM) Guidelines are developed by the Medical Policy and Technology Assessment Committee (MPTAC) or through MPTAC's adoption of an independent third-party criteria, namely MCG. These policies and clinical utilization management guidelines are the sources to determine if retrospective review is required for a particular service, and ultimately include the criteria for determining if the service is medically necessary. The evidentiary standard for this factor is simply whether a Medical Policy or Clinical UM Guideline applies to the particular M/S and MH/SUD service.

**Was Prior Authorization Required:** As detailed in the Prior Authorization NQTL analysis, each Plan has a team of qualified personnel that adopts or removes services on the prior authorization list. If a service is on the prior authorization list, a provider/facility should request review pre-service. In the event such request is not made and a claim is submitted post service, the service will be subject to retrospective review. The source for this factor is the adopted prior authorization list for the specific market. The standard is whether or not the service is included on the applicable prior authorization list, and if the provider requested prior authorization.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits?

**Post Service Review Written Process:**

Medical Policies, Clinical UM Guidelines, and the Prior Authorization list are all the subject of other NQTL comparative analyses, but they are the factors determining whether retrospective review is performed on a claim in two instances.

First, a provider or facility will submit a claim to Anthem for either M/S or MH/SUD services. The claims system will automatically look to see, through claim edits, whether a pre-service review (i.e., prior authorization) is required. If prior authorization is required, the system will look to see if that process was completed. If the prior authorization process was not completed and the health plan has in place a 100% penalty then the claim will be rejected as not authorized and sent a remittance back to the provider requesting clinical data to support the claim and ultimately for a post service clinical claim review. If the prior authorization process was not completed and a penalty is not in place, the claim will be submitted to the PSCCR team for review. When the provider/facility submits the requested clinical information, it is sent to the post service clinical claim review team for a retrospective review against the medical criteria (e.g., medical policy or clinical UM guideline) and a decision is communicated to the provider and member.



A retrospective review is also performed where a medical policy or clinical UM guidelines applies to the service performed on the claim, even if prior authorization is not required. In this instance, the claims edits will look to see if the services on the claim match up with a medical policy or clinical UM guideline. If so, the claim is sent to the post service clinical claim review team for review and comparison to the medical necessity criteria within the applicable medical policy or clinical UM guideline.

The written processes above apply to both M/S and MH/SUD claims.

**Post Service Review Operation Analysis:**

In performing the operational comparative analysis, Anthem annually pulls data from the Anthem Care Management Platform (ACMP). The data includes all retrospective reviews performed for M/S and MH/SUD claims. First, Anthem reviews the total amount of claims subject to retrospective review. A substantially higher amount of M/S claims are subject to retrospective, and account for a higher overall proportion of claims subject to retrospective review. Because Anthem requires prior authorization of inpatient services, we expect to have very few retrospective reviews unless the provider fails to preauthorize care. In the case of outpatient services, we expect the numbers of retrospective reviews to be much higher for medical/surgical services. This is because the majority of Anthem's medical policies/clinical UM guidelines are for medical/surgical services. Also, a significant number of MH/SUD services are associated with outpatient office visits. Anthem does not maintain a medical policy/clinical UM guideline for those services so no utilization management review would be performed.

Secondly, in reviewing the breakdown of M/S and MH/SUD reviews, in general, a higher proportion of MH/SUD claims are approved on retrospective review with some very limited exceptions. The comparison is provided in the attached Exhibit 2.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Anthem uses the same factors, sources, standards, and process for determining when a retrospective review is performed on MH/SUD and M/S claims. Additionally, the same process to perform the retrospective review is used for MH/SUD and M/S claims. Therefore, the written processes are within parity requirements. The operational data also confirms retrospective review is within parity requirements as a higher level of M/S claims are subject to retrospective review, and generally, a higher percentage of MH/SUD are approved on retrospective review. Therefore, in comparing the written process and operational data, Anthem's retrospective review process is within mental health parity requirements.



## **EXHIBIT 1 STANDARD FULLY INSURED EOC PROVISION**

### **Getting Approval for Benefits**

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

#### **Reviewing Where Services Are Provided**

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis in a Hospital setting but may be approved at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Certain services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

**Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:**

1. You must be eligible for benefits;





2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

### Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.  
**Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us with 48 hours of admission, or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay / Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.  
Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.
- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

### Who is Responsible for Precertification?



Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor (“requesting Provider”) will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	<ul style="list-style-type: none"><li>• The Provider must get Precertification when required</li></ul>
Out-of-Network / Non-Participating	Member	<ul style="list-style-type: none"><li>• Member must get Precertification when required (Call Member Services).</li><li>• Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.</li></ul>
BlueCard Provider	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"><li>• Member must get Precertification when required. (Call Member Services.)</li><li>• Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.</li><li>• BlueCard Providers must obtain precertification for all Inpatient</li></ul>



		Admissions.
Note: For an Emergency Care admissions, precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

### **How Decisions are Made**

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the “Complaints and Appeals” section to see what rights may be available to you.

### **Decision and Notice Requirements**

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	24 hours from the receipt of request
Non-Urgent Pre-service Review	72 hours, or 2 business days, whichever is less from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received more	24 hours from the receipt of the request



than 24 hours before the end of the previous authorization	
Urgent/Concurrent Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	1 business day from the receipt of the request
Non-urgent Concurrent Continued Stay Review for ongoing outpatient treatment	1 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.



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**EXHIBIT 2**  
**RETROSPECTIVE REVIEW**  
**GEORGIA – SELF FUNDED GROUP (ASO)–LOCAL COMMERCIAL**

**Inpatient, In-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	1141	360	76%
Group MH/SUD	124	19	86%

**Inpatient, Out-of-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	439	177	71%
Group MH/SUD	40	4	90%

**Outpatient, In-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	2280	21	99%
Group MH/SUD	11	2	84%

**Outpatient, Out-of-Network**

Line of Business	Approved	Denied	Percentage Approved
Group M/S	1941	2	99%
Group MH/SUD	8	0	100%

Note: Data is for self-funded plans whose plans are headquartered in Georgia without regard to where the members of the plan reside (e.g., group is headquartered in Georgia but members may live in-or-outside of Georgia). Data includes requests for precertification as well (i.e., services that are not on the prior authorization list). It also includes requests to see an out-of-network provider.

Report run on or around February 27, 2023 by Tina Jones, Business Info Developer Consultant, Sr.



## NQTL SELF COMPLIANCE TOOL UTILIZATION MANAGEMENT REVIEW PROCESS

### *Overview*

Anthem's fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary. This analysis explains the utilization review process itself and how Anthem's processes, strategies, evidentiary standards and other factors comply with the NQTL requirements in MHPAEA.

1. Identify the factors considered in the design of the NQTL:
  - a. Compliance with state laws governing utilization review. Such laws may vary based on (1) the state licensure requirements of the utilization review entity; (2) whether the member resides in the state; or (3) whether the policy is sold in the state.
  - b. Compliance with federal laws governing utilization review (e.g., the Employee Retirement Security Act of 1976 or the Public Health Services Act)
  - c. Compliance with NCQA accreditation requirements.
2. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Anthem Utilization Management, Inc. ("AUMSI") is the Anthem subsidiary that is licensed, where required to perform utilization management reviews of medical/surgical and behavioral health services.

The plan language that applies to our fully insured policies is attached as Exhibit 1.

### *Sources:*

- a. State laws
- b. Federal laws
- c. NCQA Accreditation requirements governing utilization review
- d. Anthem's medical policies, clinical UM guidelines or third-party guidelines (collectively "utilization management criteria")

### *Utilization Review Process:*

AUMSI performs utilization review, whether it is for a medical/surgical condition or a behavioral health condition, as follows:

UTILIZATION REVIEW PROCESS PRE-REVIEW SCREENING: Non-clinical administrative staff gather information and conduct pre-review screening under the supervision of appropriately licensed health care professionals when there are explicit utilization management criteria and no clinical judgment is required.





#### INITIAL CLINICAL REVIEW PROCESS:

Staff will complete the following steps when performing utilization review:

1. Assess the provided clinical information;
2. As needed, request additional information; and
3. Review the case against approved clinical criteria.

#### PEER CLINICAL REVIEW PROCESS

Peer clinical reviewers possess an active license or administrative license relevant to their assigned review functions. Appropriate peer clinical reviewers review all medical necessity adverse determinations for requested health care, behavioral health, and pharmaceutical services. Peer clinical review is not required for requests for services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

#### UTILIZATION REVIEW TIME FRAMES

All utilization review determination time frames are based on applicable law or, if more strict accreditation requirements, and will include verbal (direct dialog or voice mail), and/or electronic or written notification as applicable. The time period for making a determination begins on the date of receipt.

##### A. NON-URGENT CARE PROSPECTIVE REVIEW:

If AUMSI receives all the information needed to review the request, AUMSI will make a determination within a reasonable period of time appropriate to the medical situation but not later than fifteen (15) calendar days after receipt of the request.

**EXTENSION OF DECISION TIME FRAME:** If an extension is necessary because AUMSI did not receive the information necessary to make a determination, the notice of extension will specifically describe the required information. AUMSI will suspend the time period for making a determination from the date on which AUMSI sent the notice of the extension until the date the covered person responds to the request for additional information or the expiration of the applicable timeframe.

The covered person will have forty-five (45) calendar days from receipt of the notice to provide the specified information. AUMSI will make a determination: 1. Within fifteen (15) calendar days of receipt of the requested information; or 2. Within fifteen (15) calendar days of the expiration of the forty-five (45) calendar day time period if AUMSI does not receive the requested information.

**EXTENSION FOR OTHER REASONS:** If AUMSI determines that an extension is necessary due to matters beyond its control (e.g., waiting for an evaluation by a specialist), AUMSI may extend this period one time for up to fifteen (15) calendar days, provided that AUMSI determines that such an extension is necessary due to matters beyond its control and AUMSI notifies the covered person prior to the expiration of the initial fifteen (15) calendar day period of the circumstances requiring the extension of time and the date by which AUMSI expects to render a determination.



## B. NON-URGENT CARE CONCURRENT REVIEW

If AUMSI receives all the information needed to review the request, AUMSI will make a determination within a reasonable period of time appropriate to the situation, but not later than fifteen (15) calendar days after receipt of the request.

**EXTENSION OF DECISION TIME FRAME:** If an extension is necessary because AUMSI did not receive the information necessary to make a determination, the notice of extension will specifically describe the required information. AUMSI will suspend the time period for making a determination from the date on which AUMSI sent the notice of the extension until the date the covered person responds to the request for additional information or the expiration of the applicable timeframe.

The covered person will have forty-five (45) calendar days from receipt of the notice to provide the specified information. AUMSI will make a determination: 1. Within fifteen (15) calendar days of receipt of the requested information; or 2. Within fifteen (15) calendar days of the expiration of the forty-five (45) calendar day time period if AUMSI do not receive the requested information. If AUMSI issues a favorable determination for an ongoing course of treatment provided over a period of time or number of treatments, any reduction or termination before the end of such period or number of treatments will constitute an adverse determination. If AUMSI reduces or terminates a favorable determination for an ongoing course of treatment, AUMSI will notify the covered person sufficiently in advance of such reduction or termination to allow the covered person to appeal and obtain a determination on review of that adverse determination before AUMSI reduce or terminate care.

**EXTENSION FOR OTHER REASONS:** AUMSI may extend this period one (1) time for up to fifteen (15) calendar days and AUMSI notify the covered person prior to the expiration of the initial fifteen (15) calendar day period of the circumstances requiring the extension of time and the date which AUMSI expect to render a determination.

## C. RETROSPECTIVE REVIEW

If AUMSI receives all the information needed to review the request, AUMSI will make a determination within a reasonable period of time but not later than thirty (30) calendar days after receipt of the request.

**EXTENSION OF DECISION TIME FRAME:** If an extension is necessary because AUMSI did not receive the information necessary to make a determination, the notice of extension will specifically describe the required information. AUMSI will suspend the time period for making a determination from the date on which AUMSI sent the notice of the extension until the date the covered person responds to the request for additional information or the expiration of the applicable timeframe. The covered person will have forty-five (45) calendar days from receipt of the notice to provide the specified information. AUMSI will make a determination: 1. Within fifteen (15) calendar days of receipt of the requested information; or 2. Within fifteen (15) calendar days of the expiration of the forty-five (45) calendar day time period if AUMSI do not receive the requested information.

**EXTENSION FOR OTHER REASONS:** If AUMSI determines that such an extension is necessary due to matters beyond our control (e.g., waiting for an evaluation by a specialist), AUMSI may extend this



period one (1) time for up to fifteen (15) calendar days, provided that AUMSI determines that such an extension is necessary due to matters beyond our control and AUMSI will notify the covered person prior to the expiration of the initial thirty (30) calendar day period of the circumstances requiring the extension of time and the date which AUMSI expects to render a determination.

#### D. URGENT CARE PROSPECTIVE REVIEW

If AUMSI receives all the information needed to review the request, AUMSI will make a determination as soon as possible, taking into account the situation but not later than seventy-two (72) hours after receipt of the request. AUMSI may give verbal notification of an adverse determination, provided that written or electronic notification is provided to the covered person and practitioner within three (3) calendar days after the verbal notification. AUMSI records the time and date of notification and the staff member who spoke with the practitioner or covered person. Verbal notification must involve communication with a live person, a voicemail is not an acceptable form of oral notification.

If AUMSI did not receive the necessary information AUMSI will notify the covered person as soon as possible but not later than twenty-four (24) hours after receipt of the request. The covered person will have forty-eight (48) hours to give us the specified information. AUMSI will make a determination as soon as possible but in no case later than forty-eight (48) hours after the earliest of: 1. AUMSI's receipt of the specified information; or 2. The end of the forty-eight (48) hour period provided to the covered person.

**URGENT CARE CONCURRENT REVIEW PREVIOUSLY ISSUED FAVORABLE DETERMINATION REQUESTS.** AUMSI will make a determination within twenty-four (24) hours after receipt of the request, provided that the request is made at least twenty-four (24) hours prior to the expiration of the previously approved period of time or number of treatments. For requests received less than twenty-four (24) hours before the expiration of the previous favorable determination of period of time or number of treatments, AUMSI will make a determination within seventy-two (72) hours of the request.

**NOT PREVIOUSLY ISSUED DETERMINATION REQUESTS:** Concurrent urgent care review determinations will be made within twenty-four (24) hours of receipt of the request; however the request may be extended up to seventy-two (72) hours if at least one (1) documented attempt was made to obtain the needed clinical information within the initial twenty-four (24) hours of receipt of the request. AUMSI may give verbal notification of an adverse determination provided that written or electronic notification is provided to the covered person and practitioner within three (3) calendar days after the verbal notification. AUMSI records the time and date of notification and the staff member who spoke with the practitioner or covered person. Verbal notification must involve communication with a live person, a voicemail is not an acceptable form of oral notification. AUMSI may inform and send electronic or written notification to the hospital utilization review department of its determination, with the understanding that staff will inform the attending or treating practitioner. Electronic or written notification may be addressed to the hospital utilization review department but must be addressed to the attention of the attending or treating practitioner. Electronic or written notification of an adverse determination may be addressed to the hospital utilization review department but must be addressed to the attention of the attending practitioner or treating practitioner, provided that written notification is sent to all required individuals.



#### NOTIFICATION OF DECISION:

NOTIFICATION OF FAVORABLE DETERMINATIONS: AUMSI will provide notification for all favorable determinations to the covered person.

NOTIFICATION OF ADVERSE DETERMINATIONS: AUMSI will provide electronic or written notification for all adverse determinations to the covered person and attending practitioner or treating practitioner, as applicable. Electronic or written notification will include the notification requirements listed above, and the following:

1. The specific reason or reasons for the adverse determination in terms specific to the covered person's condition or request and in language that is easy to understand, so the covered person and practitioner know why AUMSI issued an adverse determination and have enough information to file an appeal. The notification includes a complete explanation of the grounds for the adverse determination, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. AUMSI are not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Adverse determination notices sent only to practitioners may include technical or clinical terms.

2. Reference to the specific plan provision(s), guideline(s), protocol(s) or similar criterion on which the determination is based. When referencing a specific plan provision(s), AUMSI must direct the covered person to the information using the section title or page number of the benefit document.

3. A description of any additional material or information necessary for the covered person to perfect the request and an explanation of why such material is necessary.

4. A description of the appeal procedures (prospective, retrospective, and expedited), including the right to submit written comments, documents, or other information relevant to the appeal, where to direct the appeal, what information to include with the appeal, and the applicable time limits for filing an appeal and the applicable time frames for appeal determinations including the covered person's right to bring a civil action under ERISA following an adverse determination on review. Notification will also include a statement of the covered person's right to request an expedited internal appeal at the same time as requesting an expedited external appeal.

5. A statement that the covered person may be represented by anyone the covered person chooses, including an attorney. The notification to the practitioner is not required to include the covered person's right to representation if the practitioner is not acting as an authorized representative.

6. If AUMSI relied on an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person, upon request.



7. If the adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

8. Information sufficient to identify the request involved (including the date of service, the practitioner, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

9. The denial code and its corresponding meaning, and any description of the standard, if any, that was used in denying the request.

10. A statement that a covered person is not required to bear costs of the IRO, including any filing fees, unless state law mandates that the covered person pays an IRO filing fee.

a. For organizations that are not subject to ERISA requirements notification to the covered person of an adverse determination for a continued stay review or retrospective review is not required if the covered person is not at financial risk.

11. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals and external appeal procedures and a description of available internal and external appeal procedures, including information regarding how to initiate an appeal, including the right to submit written comments, documents or other information relevant to the appeal.

a. For group and individual health insurance plans & self-funded non-federal government plans in states (AL, AK, FL, GA, PA, & WI) whose external appeal processes do not to meet the requirements to be an National Association of Insurance Commissioners (NAIC)-parallel process or an NAIC-similar process and the Health & Human Services-administered process has been selected, the notification must include the following information:

1. Include information that the covered person can request an external appeal in writing by submitting as follows: (a) electronically at [externalappeal.cms.gov](https://externalappeal.cms.gov), under the "Request a Review Online" heading; (b) faxing to 888-866-6190; or (c) Mailing to: MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

2. Include information that the covered person can call toll free at 888- 866-6205 for any questions or concerns during the external appeal process;

3. Provide the covered person with the opportunity to submit additional written comments to the IRO at the mailing address above and that any additional information submitted will be shared with Us to afford Us the opportunity to reconsider the adverse determination;

4. Provide the covered person with the Notice of Privacy Act Statement; and 5. Inform the covered person that: i. If they believe their case should be expedited, they can select



“expedited” if submitting the review request online, or by emailing FERP@maximus.com, or calling Federal External Review Process at 888-866-6205 ext. 3326. ii. In urgent care situations, requests for expedited review can be initiated by calling the toll free number 1-888-866-6205.

b. For a Multi-State Plan (MSP), the notification must include the following information:

1. Include information that the covered person can request an external appeal in writing by submitting as follows: (a) Via email at mspp@opm.gov; (b) Via fax at (202) 606-0033; or (c) Via mail to: MSP Program External Review National Healthcare Operations U.S. Office of Personnel Management, 1900 E Street, NW, Washington, DC 20415.

2. Include information that the covered person can call toll free at (855) 318-0714 for any questions or concerns during the external review process

3. Provide the covered person with the opportunity to submit additional written comments at the mailing address above and that any additional information submitted will be shared with AUMSI in order to provide it an opportunity to reconsider the adverse determination.

3. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

AUMSI associates who perform utilization review are required to abide by the same policies and procedures when conducting the review. To evaluate compliance, AUMSI conducts mandatory clinical adherence audits in order to ensure individual associates comply with all applicable utilization management standards and policies. If such an audit reveals a compliance rate below 90%, AUMSI implements a corrective action plan with that associate to address the deficiency. In addition, no less than annually, AUMSI conducts inter-rater reliability testing. This testing evaluates the consistency with which peer clinical reviewers and health professionals involved in the utilization review process apply criteria in decision making. Processes employed to evaluate consistency may include but are not limited to:

1. Using hypothetical UM test cases; or
2. Using a sample of UM determination files. If a sample of UM determination files is used, one of the following auditing methods will apply: (a) 5 percent or 50 of its UM determination files, whichever is fewer, or (b) NCQA “8/30 methodology,” available at <http://www.ncqa.org/portals/0/programs/8-30.pdf>; or (c) Another statistically valid method.

For 2020, utilizing hypothetical UM test cases, the inter-rater reliability testing results are as follows:

*Non-MD clinical staff (includes both medical/surgical reviews and behavioral health reviewers (e.g., nurses or social workers):*

Report completed on August 26, 2020 by the IRRA Program Administrator.

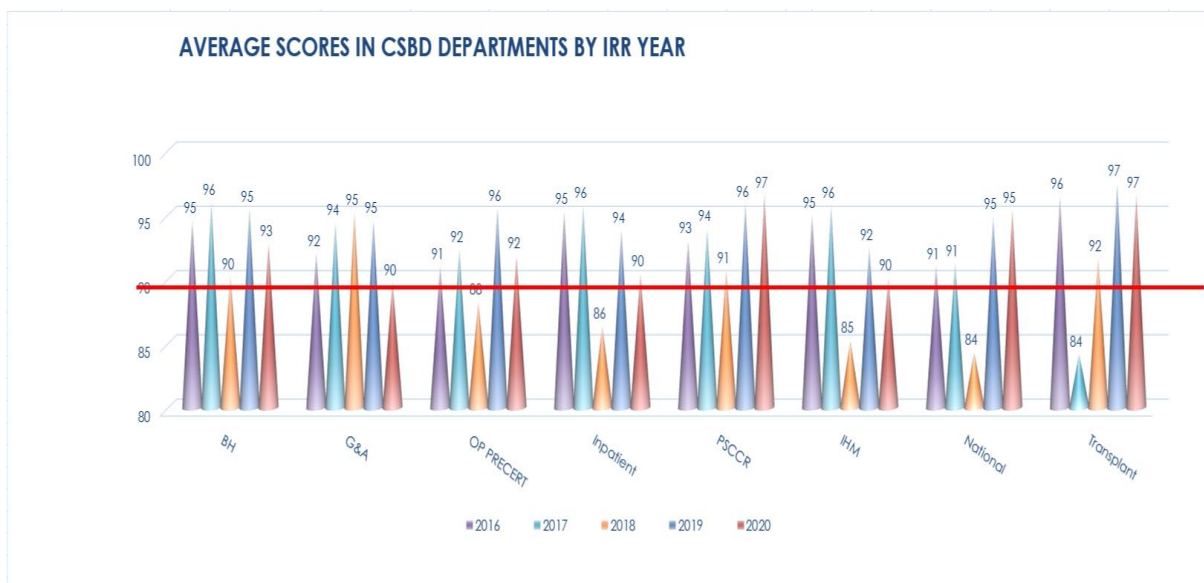




The following table shows the level of participation, percent of change, and average score over the life of the enterprise program.

Test Session	# Participants	% of Change in Participation	Average Score	Change in Score
2007-FALL	733			
2008-SPRING	1046	43%	93	
2008-FALL	1156	11%	91	-2
2009-SPRING	1480	28%	89	-2
2009-FALL	1282	-13%	90	1
2010-SPRING	1545	21%	92	2
2011-SPRING	1507	-2%	90	-2
2012-SPRING	1649	9%	91	1
2013-SPRING	1801	9%	90	-1
2014-SPRING	2143	19%	92	2
2015-SPRING	1929	-10%	92	0
2016-SPRING	1728	-10%	94	2
2017-SPRING	1588	-8%	95	1
2018-SPRING	1607	1%	87	-8
2019-SPRING	1534	-5%	94	7
2020-SPRING	1382	-10%	93	-1

For the departments where data exists for the look back period, the chart below illustrates the 5 year scoring trend for Anthem's commercial business (CSBD). The aggregate scoring for all departments have met and exceeded benchmark this year.







#### *Medical/surgical MDs:*

The reports were prepared by the Physician Interrater Reliability Committee and approved by the Commercial/Exchange Quality Improvement Committee on February 2, 2021.

Commercial physicians achieved an average score and a passing rate greater than 95% in each of the past 2 years. 2020 was the 5<sup>th</sup> consecutive year in which these values were above 90%.

<u>Year</u>	<u># of Respondents</u>	<u>Average Score</u>	<u>% Pass&gt;80%</u>
2020	169	95	96
2019	134	97	100
2018	141	92	94
2017	128	91	94
2016	144	92	96
2015	141	87	84
2014	127	88	85
2013	135	92	87
2012	126	91	89
Fall 2011	145	92	83
Spring 2011	154	89	89

#### *Behavioral Health MD Reviewers:*

Report prepared by Staff VP, National Behavioral Health Medical Director, Commercial Business Division and approved by the Behavioral Health Commercial Quality Improvement Committee on December 7, 2020.

**Goal:** Goal was for each physician to receive a score of 90% correct or more. The minimum passing score was 80% correct.

**Results:** There were 61 behavioral health physician reviewers who participated in the inter-rater reliability assessment for 2020, which included 25 employed physicians from the Anthem commercial regions, 4 regionally contracted MBO reviewers, and 32 GBD physicians. Overall results showed that 75% or 46 of the 61 physicians received a score at or above the goal of 90%, and of those, 31 physicians achieved a score of 100%. In addition, 61 physicians, 100%, achieved a passing score of 80% or more. The average score for all physicians was 94.1%. These results are above the desired goal (90%) and were comparable to results from 2019 (93.6 %), 2018 (92.5%), 2017 (91.5%) and 2016 (94%).

## DETAILS AND RESULTS BY SUBGROUP

Subgroup <sup>1</sup>	# of MD's	Average % score pre-test	Average % score post-test	# with target score of 90% or above	# with passing score between 80% & 90%	# with score below 80%
CSBD Physicians	25	96.2%	97.4%	23 (92%)	2(8%)	0
MBO Physicians	4	91.0%	90.0%	1 (25%)	3(75%)	0
GBD Physicians	32	92.0%	95.0%	22 (69%)	10 (31%)	0
Summary Results 2020	61	93.1%	94.1%	46 (75%)	15 (25%)	0

Previous Results	# of MD's	Average % score pre-test	# with target score of 90% or above	# with passing score between 80% & 90%	# with score below 80%
2019	51	90.7%	37 (73%)	13 (25%)	1 (2%)
2018	56	92.5%	40 (71%)	14 (25%)	2 (3.5%)
2017	53	91.5%	33 (62%)	18 (40%)	2 (4%)
2016	49	94%	38 (78%)	10 (20%)	1 (2%)
2015	64	92%	45 (70%)	13 (21%)	6 (9.4%)
2014	58	96%	53 (91.4%)	4 (6.9%)	1 (1.7%)
Fall 2013	39	93%	33 (84.6%)	3 (7.7%)	2 (5.1%)
Spring 2013	39	93%	31 (79.5%)	5 (12.8%)	3 (7.7%)

For 2020, all inter-rater reliability reviews, behavioral health professionals score equal to or better than their peers that review medical/surgical cases. Additionally, the clinical adherence audits, which apply equally to medical/surgical and behavioral health reviewers, ensure all associates are performing their jobs according to AUMSI policies and procedures.

The results of AUMSI's auditing and testing confirm that AUMSI does not apply these processes, strategies and evidentiary standards more stringently to MH/SUD benefits than medical/surgical benefits.

<sup>1</sup> CSBD represents the physicians who support our commercial business (individual and group). MBO represents the physicians who work for AUMSI on a temporary contract basis. GBD represents the physicians who support our Medicaid and Medicare business.



## EXHIBIT 1 STANDARD FULLY INSURED EOC PROVISION

### REQUESTING APPROVAL FOR BENEFITS

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Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

#### ***Reviewing Where Services Are Provided***

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical Facility, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Certain services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies or clinical guidelines, You may call the Member Services phone number on the back of Your Identification Card.



**Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:**

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

### ***Types of Reviews***

- **Prior Authorization Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date, including but not limited to pre-admission review, pretreatment review, Utilization Review and Case Management.
  - o **Precertification** – A required Prior Authorization Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Prior Authorization and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification. Post-service reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.



### ***Who is Responsible for Precertification***

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor (“requesting Provider”) will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
Network	Provider	The Provider must get Precertification when required.
Non-Network	Member	<p>Member has no benefit coverage for a Non-Network Provider unless:</p> <ul style="list-style-type: none"><li>• The Member gets approval to use a Non-Network Provider before the service is given; or</li><li>• The Member requires an Emergency Care admission (See note below).</li></ul> <p>Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.</p>
BlueCard® Provider	Member (Except for Inpatient admissions)	<ul style="list-style-type: none"><li>• Member must get Precertification when required (call Member Services).</li><li>• Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.</li></ul>
<p>Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.</p>		



### ***How Decisions are Made***

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the “If You Have a Complaint or an Appeal” section to see what rights may be available to You.

### ***Decision and Notice Requirements***

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, We will follow State laws. If You live in and/or get services in a State other than the State where Your Contract was issued, other State-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
<b>Precertification Requests</b>		
Prior Authorization Review Urgent	36 hours from the receipt of request, including one business day If the Member receives an Emergency service that requires immediate post evaluation or post stabilization services, We will provide an authorization decision within 60 minutes of receiving the request; if the authorization decision is not made within 60 minutes, such	For approval determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within two business days of the decision.  For Adverse Determination, We

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
	services shall be deemed approved.	will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the decision.
Prior Authorization Review Non-Urgent	36 hours from the receipt of the request, including one business day	
Urgent Continued Stay/Concurrent Review when no previous days authorized	One business day from the receipt of all necessary information	For approval determination, We will notify the Provider by telephone or electronically within one business day of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification.
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Concurrent / Continued Stay Review Non-Urgent	One business day from the receipt of all necessary information	For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. The service will continue without Member liability until the Member has been notified of the determination.
Post-service Review	30 business days from the receipt of the request	We will notify the Member by written means of the determination within 10 business days of the determination.

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.





We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

If We authorize medical services, We will not subsequently retract Our authorization after the services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless: Such authorization is based on a material misrepresentation or omission about the Member's health condition or the cause of the health condition; or more than 45 working days have passed since Our authorization and the services have not been provided; or the Member's coverage terminates before the services are provided.

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