



[REDACTED]
[REDACTED]
Treating Physician, MD
[REDACTED] · [REDACTED] · [REDACTED]

[REDACTED]

Anthem Blue Cross Life and Health Insurance Company
Grievances and Appeals
P.O. Box 60007
Los Angeles, California 90060-0007

RE: Appeal — Post-Exhaustion Escalation

Patient: Patient A | DOB: [REDACTED] | Member ID: [REDACTED]

Provider: Treating Physician, MD | NPI: [REDACTED]

Plan: Anthem Blue Cross Life and Health Insurance Company

Claims: Claim 1 ([REDACTED]) · Claim 2 ([REDACTED]) · Claim 3 ([REDACTED]) · Claim 4 ([REDACTED])

Drug: Datopotamab Deruxtecan-dlnk (Datroway) | J9011 / J9011JW

Total Denied: \$124,439.44 | Denial Dates: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]

Auth Orders: Auth Order 1 and Auth Order 2

Request: Reprocess and pay all four claims in full — J9011 / J9011JW lines

NOTICE: THIS FILING REQUIRES SENIOR REVIEW — DO NOT ROUTE TO STANDARD DISPUTE STAFF

This filing is not appropriate for standard provider dispute review staff and must not be processed through Anthem's routine dispute adjudication workflow. Three specific conditions require escalation to senior claims leadership, provider contracting authority, or Anthem's legal department before any determination is made.

First, this filing documents irreconcilable contradictions within Anthem's own systems. Anthem's Cargon authorization arm approved J9011 Datopotamab Deruxtecan-dlnk for this provider under two separate orders, both active during every denied date of service, while Anthem's claims adjudication arm simultaneously denied payment to the same provider for the same drug. On those same claims, Anthem's adjudication system applied CO-45 contracted rate reductions to infusion administration services billed under the identical NPI it simultaneously denied as non-contracted for the drug lines. These are not disputed interpretations. They are documented contradictions within Anthem's own records that standard dispute staff have neither the authority nor the institutional standing to resolve.

Second, this filing documents violations of California Health and Safety Code §1367.01(h)(3) and California Insurance Code §10123.147, which are the subject of a formal complaint filed concurrently with this letter to the California Department of Insurance. A standard dispute uphold issued without written engagement with these statutory violations will be submitted

to the CDI as evidence that Anthem's internal review process does not provide the meaningful, consistent review California law requires.

Third, a completed CDI Health Care Provider Request for Assistance form is being filed simultaneously with this letter. The regulatory track is active and running in parallel regardless of how this internal filing is resolved.

The Authorization Anthem Issued — Then Denied Against

On [REDACTED], Anthem's Carelon system authorized the treating provider's specific NPI to administer J9011 Datopotamab Deruxtecan-dlnk to this patient under Auth Order 2, valid from that date through [REDACTED]. That authorization specifically and unambiguously named the group NPI as the authorized dispensing provider. On [REDACTED] — one calendar day later — Anthem's claims adjudication system denied payment for that administration on the stated ground that the same NPI was not contracted or authorized to bill for this service.

This is not a case where an authorization was issued under a different NPI than the billing NPI. The authorization and the denial reference the identical legal entity under the identical NPI number. No contracting change was made between [REDACTED] and [REDACTED]. No rescission of Auth Order 2 was issued. No notification of any contracting or network status change was provided to this practice. Anthem's authorization arm and its claims arm issued irreconcilable determinations about the same provider entity, the same NPI, the same drug, and the same patient within a 24-hour period.

The Auto-Approval Paradox

Auth Order 2 warrants particular attention because it forecloses any argument that the denials reflect more thorough clinical review than the authorizations.

When Anthem issued Auth Order 2, its Carelon system had no clinical documentation to review. Zero physician notes. Zero treatment orders. Zero medical records of any kind. The system reviewed this patient's diagnosis, stage, and biomarker profile and determined, without a single attached document, that seven additional cycles of J9011 were appropriate for a patient at 5th Line Plus treatment and ECOG 2 performance status.

Anthem's claims reviewers, when they denied payment for these four cycles, had access to substantially more clinical information than Carelon ever evaluated for Auth Order 2: the treating physician's documented rationale, the chemotherapy plan, the administration records, the molecular testing results, and the prior authorization approvals themselves. They reviewed a profile that was the same or less clinically advanced and reached the opposite determination.

Anthem's automated authorization arm determined this drug was appropriate for this patient at the most clinically demanding profile documented in this record, with no supporting documentation. Its claims arm reached the opposite conclusion at a less demanding profile with a complete chart. That is not a more rigorous clinical process. It is a system that is not communicating with itself — and this patient and this practice are carrying the financial consequence of that failure.

Anthem's Own Claims Adjudication Confirms This Practice Is Contracted

Anthem's denial argument — that this practice is not contracted or not authorized to bill — is directly contradicted by Anthem's own claims adjudication conduct on these same dates.

On every one of the four denied claims, Anthem processed and paid the infusion administration services billed on the same claim, on the same date, under the same NPI: CPT 96413, CPT 96367,

J2405, and J1100. Anthem applied adjustment code CO-45 — “Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement” — to those lines and issued payment at the contracted rate.

CO-45 is not a generic payment adjustment. It is a contracted rate reduction code. It applies only when a provider has an established contracted fee schedule with the payer and the billed charge exceeds the rate specified in that contract. CO-45 cannot be applied to an uncontracted provider because an uncontracted provider has no contracted fee schedule rate from which a reduction can be calculated.

Anthem applied CO-45 to this practice's infusion services on [REDACTED], [REDACTED], [REDACTED], and [REDACTED] — four times, one per claim, under the same NPI. Each CO-45 application is Anthem's own affirmative determination that this practice holds a valid contract with an established fee schedule. Anthem made that determination four times on these same claims while simultaneously denying the J9011 drug lines on the stated ground that this practice is not contracted or allowed to bill.

Both determinations are on the same claim. Both are under the same NPI. Both are Anthem's. They cannot coexist.

For Anthem to sustain the uphold of any of these four claims, it must explain in writing how it calculated a contracted rate reduction for this provider's services on a date it also determined this provider was not contracted to bill. That explanation does not exist. Anthem has never issued a recoupment demand, an overpayment notice, or any other communication indicating that the CO-45 payments were made in error. Those payments stand as Anthem's operative, unchallenged adjudication that this practice is contracted with an established fee schedule.

Three Inconsistent Denial Justifications in Anthem's Own Correspondence

Anthem's own correspondence demonstrates that it cannot maintain a consistent denial basis.

Claim inquiry responses for two dates of service, dated [REDACTED], stated: “Claim denied correctly. No coverage for non-participating.”

Anthem's internal claim inquiry response for a third date of service, dated [REDACTED], stated something materially different: “Exception indicator showing X ‘DENY-NOT PAYABLE PROCEDURE’ there is no Pricing to allow those line.”

The uphold letters across all dispute levels then stated a third formulation: “not contracted or allowed to bill for this service or the service was billed incorrectly.”

Three different explanations for the same denial pattern, issued by Anthem's own personnel across its own correspondence within a 65-day period.

“No coverage for non-participating” is a coverage exclusion argument.

“There is no Pricing to allow those line” is an administrative fee schedule gap — Anthem's own words identifying a missing pricing entry, not a provider contract deficiency.

“Not contracted or allowed to bill or billed incorrectly” is a triply disjunctive contracting and billing claim.

None of these positions is consistent with the others. A payer that cannot identify its own denial basis consistently across its own correspondence cannot sustain any of the three positions at CDI or at Independent Medical Review. This documented pattern of shifting justifications is a central exhibit in this practice's CDI complaint.

What the Denial Codes Actually Reveal

CO-96 with Remark Code N448 — applied to three of the four claims — states: “This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.”

This code describes a fee schedule pricing entry gap — not a finding that this practice lacks a contract or is not authorized to bill.

Anthem's own internal claim inquiry response confirmed the mechanism in Anthem's own words: “Exception indicator showing X ‘DENY-NOT PAYABLE PROCEDURE’ there is no Pricing to allow those line.”

The exception indicator reflects a missing pricing entry — an administrative gap in Anthem's fee schedule — not a contractual disqualification of this practice.

Anthem's own Medical Policy confirmed that J9011 was added to the coverage framework effective [REDACTED] — the same date the code became effective nationally. If Anthem's clinical policy system recognized J9011 and added it to the coverage framework on that date, but Anthem's contracted fee schedule had not yet been updated to include a pricing entry, the administrative responsibility for that gap rests with the payer. This practice obtained prior authorization for J9011 from Anthem's own Carelon system before the first administration. When Anthem's utilization management arm approves a drug and issues a valid authorization, a provider has performed every available verification step. Anthem cannot transfer the financial cost of its own fee schedule update lag to the practice that administered the drug Anthem authorized.

The N448 fee schedule gap argument is directly refuted by Anthem's own adjudication conduct. On every one of the four denied claims, Anthem applied CO-45 to the infusion administration lines and issued payment at the contracted rate. CO-45 applies only where a contracted fee schedule exists. Anthem applied CO-45 four times on these same claims, under the same NPI, on the same dates it denied the J9011 drug lines under CO-96/N448.

Both cannot be correct. Anthem's CO-45 conduct is the most direct available evidence that J9011's absence from the fee schedule was a pricing omission — and the financial consequence of that omission belongs to Anthem, not to the practice that administered the drug Anthem authorized.

Anthem's response to this appeal is required within the timeframe required by California Insurance Code and this practice's provider agreement.

Additional supporting documentation is available upon request.

Respectfully submitted,

[REDACTED]
Treating Physician, MD

NPI: [REDACTED] (Individual) / [REDACTED] (Group)

This document has been anonymized for distribution. All patient, provider, practice, and claim identifying information has been removed or generalized. The denial codes, adjustment codes, internal correspondence language, adjudication conduct, statutory citations, and contradiction analysis reflect the actual record of a resolved case in which all four denied claims were reversed and paid in full.

If your practice has specialty drug claims in your write-off column that went through your full appeals process and could not be moved, the same forensic methodology applies to your records. The contradictions documented here are not specific to this drug or this payer. They appear wherever payer adjudication systems generate administrative denials while engineering denial letters to conceal the actual basis.