

REVISION DATES: 1/31/2018; 09/30/2015

General Information

This chapter offers general guidance to providers.

For specific information regarding covered transplant services, requirements, limitations, and exclusions refer to:

- AHCCCS Medical Policy Manual (AMPM) Policy 310-DD
- Reinsurance Policy Manual
- Arizona Administrative Code
 - A.A.C. R9-22-201 et. seq
 - A.A.C. R9-22-203 describes experimental services
 - A.A.C. R9-22-206 delineates covered and excluded transplants for Adults.

The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at:

<https://www.azahcccs.gov/shared/MedicalPolicyManual/>.

The Reinsurance Policy Manual is available at:

<https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/>.

The AHCCCS website also offers a link to the Arizona Administrative Codes. The AHCCCS website is available at:

<https://www.azahcccs.gov>

AHCCCS covers medically necessary transplants for members. In order to be covered, a transplant must be medically necessary, not experimental, and not for the purposes of research. Transplant services must be federally and state reimbursable.

Although transplant coverage is limited for individuals age 21 and older (adults), AHCCCS covers all medically necessary, non experimental transplants for individuals under the age of 21 under the EPSDT Program. For transplantation coverage limits for adults please refer to AMPM Policy 310-DD.

Members of the Federal Emergency Services Program (FES) are not eligible to receive transplant services.

Billing Requirements

AHCCCS contracts with providers to provide covered transplant services to eligible members.

The specialty contract specifies the inpatient, outpatient, and ancillary services that are included for transplants, and the payment amount to be received for the services provided.

The provider must notify the AHCCCS Division of Health Care Management (DHCM) that an AHCCCS member requires a transplant procedure.

DHCM will negotiate the contract terms with the provider, unless there is already a contract in place for the services to be provided.

The contractor shall submit a packet of all individual claims for all transplant related services, as a transplant service billing component. The contractor shall submit this packet using the coversheet included in the specialty contract.

The contractor is responsible for billing AHCCCS within six months of the end date of each of the transplant service billing components. Timeliness of the claim submission for each billing component of the transplant will be based on the received date for the complete set of claims related to the component.

Claims initially received beyond the six month time frame will be denied.

Under certain circumstances, when a service is outside of the transplant components that can be billed to reinsurance, those services may be billed to Fee-For-Service. If a Fee-For-Service claim is initially received within the six month time frame, the Contractor has up to twelve months from the end date of the billing component to resubmit the claim and achieve clean claim status or to adjust a previously processed claim. If a claim does not achieve clean claim status or is not adjudicated correctly within twelve months of the end date of the billing component, AHCCCS is not liable for payment.

Please note that there is a difference in timeline submission for the transplant component claims going to reinsurance and the services that can be billed to Fee-For-Service. For further information regarding where components should be billed please see the Reinsurance Policy Manual.

- Both reinsurance and Fee-For-Service claims must be initially submitted within six months of the date of service.
- Fee-For-Service claims may be resubmitted after the initial claim submission and must achieve clean claim status, including full adjudication of the claim, within twelve months of the date of service.
- Per the Reinsurance Policy Manual, reinsurance claims may be resubmitted after the initial claim submission and must achieve clean claim status, including full adjudication of the claim, within fifteen months of the date of service. It can take up to 45 days to process and adjudicate a reinsurance claim, so these claims should be submitted at least 45 days prior to the fifteen month deadline.

All medically necessary services provided to the transplant member, that are related to the transplant, should be billed using the appropriate diagnosis codes, CPT and HCPC procedure codes, and revenue codes to meet clean claim status.

Fee-For-Service transplant packages should be sent to:

AHCCCS Administration
ATTN: Reinsurance Finance Unit
Mail Drop 6100
P.O. Box 1700
Phoenix, AZ 85002

Refer to the Specialty Contract for additional claim submission requirements.

Pricing and Reimbursement

Services will be reimbursed based on the terms of the specialty contract.

DHCM will provide the Reinsurance Department with the payment requirements, including the provider name and number under which claims are to be submitted.

DHCM will review the case stage or the component package submitted, and the services will be paid according to the terms of the contract.

Medically necessary covered transplant related services that are not included in the transplant contract should be billed to AHCCCS Fee-For-Service and are subject to prior authorization requirements. See Policy 310-DD for covered transplant related services.

The Contractor agrees to bill and accept payments from AHCCCS for Fee-For-Service members. Payments will be consistent with the rate schedule included with the specialty contract, state and federal law, and the terms of the agreement.

References

For information on transplants please refer to the following references:

- AMPM Policy 310-DD, Covered Transplants and Related Immunosuppressant Medications
- The AHCCCS Contracts, including specialty contracts.
- The Reinsurance Policy Manual, which is available at:
<https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/>
- Arizona Administrative Code
 - A.A.C. R9-22-201 et. seq
 - A.A.C. R9-22-203

- A.A.C. R9-22-206

Revision History

Date	Description of changes	Page(s)
1/31/2018	Updated clean claim submission timeframe Updated references Updated difference in timelines between FFS and Reinsurance claim submissions Updated FFS Address Formatting	2 1 & 3 2 3 All
09/30/2015	New format Removed benefit lists/chart and added reference to current coverage in AMPM 310-DD Updated billing and reimbursement sections to conform to current specialty contract language	All