



Reinsurance Policy Manual

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General Information

I. Introduction

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services incurred for a member beyond an annual deductible level. The Arizona Health Care Cost Containment System (AHCCCS) is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage. This risk-sharing program is available when the provisions delineated in this manual, the AHCCCS Medical Policy Manual (AMPM) and the contract are met. Failure to comply with any of the provisions in the contract, this manual, or other program materials may result in denial of reinsurance reimbursement.

All due dates denote on or before 5:00 p.m. on the due date indicated. If the due date lands on a weekend or State recognized holiday then the due date is the next **business** day on or before 5:00 PM.

II. Purpose & Overview

The purpose of the manual is to provide general information regarding the AHCCCS reinsurance program, including the requirements for eligibility, determination of benefits, and deductible rate.

The primary objective of the manual is to establish consistency and uniformity in the processing of reinsurance. Throughout the manual a toolbox icon (see below) will be displayed which will indicate to the reader when to click on a hyperlink to take the reader to the AHCCCS website for more detailed information for a process. Not every process step can be included in this manual and because of that the Reinsurance Team has prepared several tools to assist in processing reinsurance.



Toolbox Icon

III. Definitions/Acronyms

ACOM	AHCCCS Contractor Operations Manual
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care System
AMPM	AHCCCS Medical Policy Manual provides information regarding covered health care services and is available on the AHCCCS website.
BHS	Behavioral Health Services means the assessment, diagnosis, or treatment of an individual's behavioral health issue and include services for both mental health and substance abuse conditions.

BIOTECH DRUGS	Biotech is the term used for biotechnology or products produced by Biotechnology. These drugs are also called biologicals, biotech drugs, Biological drugs, or biopharmaceuticals. The drugs covered are detailed in chapter five of this manual.
CASE	A record comprised of one or more adjudicated encounter(s).
CASE TYPE	A description of the type of reinsurance being paid to the Contractor based on the member's medical condition and eligibility. PMMIS Screen RF776 lists case types.
CMDP	Comprehensive Medical and Dental Program - A department within the Arizona Department of Child Safety that is responsible for managing the medical needs of foster children in Arizona under A.R.S. § 8-512.
CLEAN CLAIM/ CLEAN STATUS/ CLEAN ENCOUNTER	A claim/encounter that may be processed without obtaining additional information from the provider or Contractor of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, and has passed all of the Encounter and Reinsurance edits within the 15 month timely filing deadline.
COINSURANCE	The percentage rate at which AHCCCS will reimburse the Contractor for covered services above the deductible.
CONTRACTOR	An organization or entity that has a prepaid capitated contract with the AHCCCS administration to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statutes and Rules, and Federal law and regulations.
CONTRACT YEAR	The contract year for reinsurance is the twelve month period beginning on October 1 st through and including September 30 th . The contract year may not coincide with the term of a contract as specified in Section A of an entity's contract with AHCCCS.
CRS	Children's Rehabilitative Services is a program that provides for medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C.22.
DEDUCTIBLE	The annual amount of reinsurance covered services that must be paid and encountered by a Contractor for each individual member before the Contractor receives reinsurance payments from AHCCCS.
DHCM	Division of Health Care Management
DOS	Date of Service
ENCOUNTER	A record of health care related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.

GAUCHER'S DISEASE	An inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulates in the spleen, liver, bone marrow and, in rare cases, the brain.
GENERAL MENTAL HEALTH (GMH)	A classification of diagnoses that is not Seriously Mentally Ill; these diagnoses are not so severe that people cannot function without intense services and medication(s).
GMH/SA DUAL	An acronym frequently used to describe a member who has both classifications of GMH and SA.
HEMOPHILIA	This is a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation . There are three types of hemophilia, A, B, and C. The severity of hemophilia is related to the amount of clotting factor in the blood.
IMD	Institution for Mental Disease
INTEGRATED CONTRACTOR	Integrated healthcare Contractors that provide both Acute and Behavioral Health services.
MM	Medical Management
PPC	Prior Period Coverage is the period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor.
PROSPECTIVE	The period of time from when the Contractor receives notification the member has been assigned to their plan and they are prospectively capitated for the member.
PT	Provider Type
RBHA	Regional Behavioral Health Authority is an organization under contract with the ADHS to administer covered behavioral health services in a geographically specific area.
RI	Abbreviation for Reinsurance
RTC	Residential Treatment Center
SA	Substance Abuse: As specified in A.A.C. R9-10-101, an individual's misuse of alcohol or other drug or chemical that: a. Alters the individual's behavior or mental functioning; b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and c. Impairs, reduces, or destroys the individual's social or economic functioning.

SNF	Skilled Nursing Facility: Nursing facility for those members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.
SUBSTANCE ABUSE (SA)	Substance Abuse is the use of illegal substances like illegal drugs and prescription drugs; it also includes using substances in ways other than intended like gasoline, household chemicals, etc.
TITLE XIX MEMBER	Members include those members eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work. The funding source is different from a Title XXI member therefore the payments are accounted for separately by AHCCCS.
TITLE XXI MEMBER	Member eligible to receive services under Title XXI of the Social Security Act. The funding source is different from a Title XIX member therefore the payments are accounted for separately by AHCCCS.
TPL	Third Party Liability
Von WILLEBRAND'S	An inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

Chapter One: Acute and CMDP Contractors Regular Reinsurance

I. Eligibility

Regular Reinsurance (RAC case type) is available to partially reimburse the Contractors participating in the Acute Care Program for covered inpatient facility services, with limitations, as described in contract, the AMPM, and this manual, when the cost of care for a member exceeds an annual deductible amount. Except as described below, members who are prospectively enrolled with an Acute Contractor on a capitated basis and meet the appropriate deductible amount may qualify for Reinsurance reimbursement. Members who are eligible under, State Only Transplants and Prior Period Coverage, (PPC) do not qualify for RAC. The deductible amounts and coinsurance percentages are detailed in contract. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered inpatient facility services incurred above the deductible.



Form Types:

- ❖ Form Type **I or L**

II. Determination of Reinsurance Benefits

Services that are covered under Regular Reinsurance are specified in the AHCCCS Reinsurance System on the RI325 screen entitled “RI Covered Services.”

In addition to inpatient facility services, per diem rates paid for nursing facility services provided within thirty (30) days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to ninety (90) paid days in any contract year may qualify for Regular Reinsurance coverage.



Services provided at mental health residential treatment centers and subacute facilities are not eligible for reinsurance reimbursement.

Provider Types:

- ❖ Subacute: B1, B2, B3, B5, B6
- ❖ Mental Health Residential Treatment Center: 78

PPC inpatient expenses are not covered under the Regular Reinsurance program for any members except as described under transplant reinsurance. Encounters with PPC contract types will not be eligible for reinsurance and encounters with both PPC and Prospective eligibility segments should not be split and are not eligible for reinsurance.

In order to determine whether a claim qualifies for reinsurance reimbursement, AHCCCS evaluates the adjudicated encounters for services that have been provided. The following is a summary (the RI 325 screen in PMMIS provides the details) of the services covered under Regular Reinsurance:

- Inpatient services
Acute Care Facility – PT 02
Inpatient Services provided in an acute care facility. Encounters in which the day of admission and the day of discharge are the same, (referred to as a “same day admit and

discharge”) are valued on the outpatient hospital fee schedule and are not eligible for reinsurance coverage. Encounters in which the day of admission and the day of transfer are the same, (referred to as “same day admit and transfer”) are eligible for reinsurance coverage.

Arizona Department of Health Services (ADHS) Facility - PT 71

Inpatient services provided in an accredited psychiatric hospital as licensed by ADHS.

- Skilled Nursing Facility Services

Skilled Nursing Facility - PT 22

Skilled Nursing Facility Services provided within thirty (30) days post discharge of an acute care stay, limited to ninety (90) paid days per contract year. The Skilled Nursing Facility stay must be the first continuous Skilled Nursing Facility stay post inpatient discharge, e.g. Inpatient stay ends 1/1 and member is admitted to a Skilled Nursing Facility on 1/14 and discharged on 1/20; a second admission to the Skilled Nursing Facility is not eligible for reinsurance unless there is an additional Inpatient stay preceding the second admission.

- Specialty Per Diem Facilities – PT C4

Inpatient services provided in Specialty Per Diem Facilities, specifically Long Term Acute Care (LTAC) facilities.

- Care provided in a Medicare certified Institution for Mental Disease (IMD) for individuals over 64 years of age.

- Reinsurance covered services are listed in detail on the RI 325 screen in PMMIS.

There can only be one Regular Reinsurance case per AHCCCS enrolled recipient per contract year, per Contractor.

Reinsurance Reports

The following reports (available in comma delimited format or report text format) are available via the AHCCCS FTP Server for Contractors' use and reference:

RI91L205 - Reinsurance Pend Report

This report is a summary of case information for all active cases that have pending reinsurance encounters during that reporting period. It lists the edit codes, edit descriptions, and edit counts.

RI81L310 - Reinsurance Remittance Advice Report

This report is generated after the monthly reinsurance payment cycle, and is a summary of all financial activity applied to only those cases that were included in the payment cycle. Financial activity and reinsurance encounters detailed on the Reinsurance Remittance Advice include payments, replacements, voids, recouments and denials.

RI91L105 - Reinsurance Case Summary Report

This report is a summary of case information for all active cases during the monthly reinsurance cycle and lists the status of all reinsurance encounters associated to each reinsurance case. Also included are the case level totals for the allowed amount, liability, deductible, premium tax paid and total paid.

RI91L100 - Reinsurance Case Initiation Report

This report is a summary of case information created during the previous month's reinsurance case creation cycle including encounter information for those encounters associated to the cases created in the reporting period.

RI91L315 - Reinsurance Case Reconciliation Report

This report is a summary of case information with a detailed listing of encounters that potentially apply to an active reinsurance case but have not been associated to the case due to pend errors. Also included are those encounters in the edit/audit process to enable reconciliation of the encounter records with the reinsurance records.

III. Deductibles

AHCCCS is self-insured for the reinsurance program which is characterized by an annual deductible level established for each member for the reinsurance contract year which is October 1st through September 30th. The deductible is the responsibility of the Contractor and is subject to change by AHCCCS. Any change in the annual deductible amount would have a corresponding impact on capitation rates.

When a member enrolled with an Acute Care Contractor changes Contractors within a contract year, for reinsurance purposes, all eligible inpatient costs, nursing facility costs and inpatient psychiatric costs incurred for that member do not follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level.

Annual deductible levels apply to all members except for State Only Transplant members.

Reinsurance Case Type	Deductible	Coinsurance
Regular Reinsurance-Acute Contractors <i>Including reinsurance for dual eligible members with GMH/SA needs</i>	\$25,000	75%
Regular Reinsurance-CMDP Contractor	\$20,000	75%

These deductible levels are subject to change by AHCCCS during the term of this contract. Any change in deductible levels will have a corresponding impact on capitation rates.

Chapter Two: ALTCS Contractors Regular EPD Reinsurance

I. Eligibility

- ❖ LMO = Long-term care Metro w/out Medicare
- ❖ LRO = Long-term care Rural w/out Medicare
- ❖ LMW = Long-term care Metro w/Medicare
- ❖ LRW = Long-term care Rural w/Medicare

Regular ALTCS Reinsurance (LMO, LRO, LMW and LRW case types) is offered to partially reimburse the Contractors participating in the ALTCS Elderly and Physically Disabled Program for covered services as described in contract, the AMPM and this manual, when the cost of care for a member exceeds an annual deductible amount. All members who are prospectively enrolled with a Contractor on a capitated basis and meet the appropriate deductible amount may qualify for reinsurance reimbursement. The deductible amounts and coinsurance percentages are detailed in contract. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible.



Form Types:

- ❖ Form Types **I**

LMW or LRW:

- ❖ Member must have Medicare **Part A or Part C**

II. Determination of Benefits

Services that are covered under reinsurance are specified in the AHCCCS Reinsurance System on the RI325 screen entitled "RI Covered Services." Not all AHCCCS covered services are covered by Reinsurance. Long term care services or services usually covered under a facility's room and board charges are excluded from ALTCS Reinsurance benefits.

AHCCCS will use eligible adjudicated encounters, including but not limited to, outpatient and inpatient facility, professional, dental and pharmacy encounters to determine reinsurance benefits for regular ALTCS reinsurance cases. Effective for the contract year beginning October 1, 2011, the regular ALTCS reinsurance case **will not** be created until an inpatient stay has occurred. If a BEH or BIO case type was established for the member at the beginning of the Contract Year then it is necessary for the Contractor to submit a RAR form and the Reinsurance Case Creation form to establish the LMO, LRO, LMW, or LRW case type. If there is no inpatient stay for the member within the contract year, no regular ALTCS reinsurance case will be created. If there is an inpatient stay during the contract year, then the regular ALTCS case is created from the inpatient encounter, and will then associate all encounters for all eligible reinsurance covered services within the contract year.

Prior Period Coverage (PPC) expenses are **not covered** under the reinsurance program for any members except as described under transplant reinsurance. Encounters with PPC contract types will not be eligible for reinsurance and encounters with both PPC and Prospective eligibility segments should not be split and are not eligible for reinsurance

III. Deductibles

The deductible level is based on the Contractors' statewide ALTCS enrollment as of October 1st of each contract year.

When a member with an annual enrollment choice changes Contractors within a contract year, for reinsurance purposes, all eligible inpatient costs, nursing facility costs and inpatient psychiatric costs incurred for that member **do not** follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level.

<i>Statewide Plan Enrollment</i>	<i>Deductible with Medicare Part A</i>	<i>Deductible Without Medicare Part A</i>	<i>Coinsurance</i>
0-1,999	\$10,000	\$ 20,000	75%
2,000+	\$20,000	\$ 30,000	75%

These deductible levels are subject to change by AHCCCS during the term of this contract. Any change in deductible levels will have a corresponding impact on capitation rates.

Chapter Three: ALTCS Contractors DDD Regular Reinsurance

I. Eligibility

Regular reinsurance (DES case type) is available to partially reimburse the Contractor participating in the Developmentally Disabled (DD) Services Program for covered inpatient facility services as described in contract, the AMPM and this manual, when the cost of care for a member exceeds an annual deductible amount. Except as described below, members who are prospectively enrolled with the DD Contractor on a capitated basis and meet the appropriate deductible amount may qualify for Reinsurance reimbursement. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered inpatient facility services incurred above the deductible.

II. Determination of Benefits

Services that are covered under Regular Reinsurance (DES) are specified in the AHCCCS Reinsurance System on the RI325 screen entitled "RI Covered Services."

III. Deductibles

The deductible level is a set amount of \$50,000 established as of October 1st of each contract year.

Chapter Four: CRS Contractor Reinsurance

I. Eligibility

Regular Reinsurance is available to partially reimburse the Children’s Rehabilitative Services Program (CRS) Contractor for covered inpatient facility services as described in contract, the AMPM and this manual, when the cost of care for a member exceeds an annual deductible amount. Except as described below, members who are prospectively enrolled with the CRS Contractor on a capitated basis and meet the appropriate deductible amount may qualify for Reinsurance reimbursement. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered inpatient facility services incurred above the deductible.

II. Determination of Benefits

Services that are covered under regular reinsurance (see case types below) for the CRS Contractor are detailed in the AHCCCS Reinsurance System on the RI325 screen entitled “RI Covered Services.” The specific case types on the RI325 screen used to identify the four coverage types are as follows:

CASE TYPE	CASE TYPE DESCRIPTION	Contractor ID
CFI	CRS Fully Integrated	010115
CPA	CRS Partially Integrated – Acute	010145
CPB	CRS Partially Integrated – Behavioral Health	999125
CRS	CRS Only	999135

III. Deductibles

Case Type	Deductible	Coinsurance	Coverage Type
Regular Reinsurance	\$75,000	75%	CRS Fully Integrated CRS Partially Integrated – Acute CRS Partially Integrated – BH CRS Only
Catastrophic Reinsurance	NA	85%	CRS Fully Integrated CRS Partially Integrated – Acute CRS Partially Integrated – BH (limited applicability – see below) CRS Only (limited applicability – see below)
Transplant Reinsurance	See Chapter 7	See Chapter 7	CRS Fully Integrated CRS Partially Integrated – Acute
Other Reinsurance	See specific paragraphs below	See specific paragraphs below	CRS Fully Integrated CRS Partially Integrated – Acute CRS Partially Integrated – BH CRS Only

The deductible level is a set amount established as of October 1st of each contract year.

The deductible level is subject to change by AHCCCS during the term of this contract. Any change in deductible level will have a corresponding impact on capitation rates.

Deductible Carryover (applicable to the CRS Contractor only) - When a member remains eligible for CRS but changes coverage types within a contract year, **regular** reinsurance eligible costs will follow the member and a new deductible will not have to be satisfied.

It is not necessary to split encounters when the member moves from one CRS coverage type to another.

Chapter Five: Catastrophic Reinsurance

I. Eligibility

Catastrophic reinsurance is available to partially reimburse the Contractor for the cost of care associated with certain medical diagnoses, specific biotech drugs, pregnancy terminations, and high cost behavioral health conditions as described below and in the AMPM posted on the AHCCCS website (see hyperlink below).

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf>

Catastrophic reinsurance is obtained by submitting a request and medical documentation to the AHCCCS MM within 30 days of the identification of the catastrophic case. Catastrophic reinsurance will be retrospectively provided for a maximum of 30 days from the date the request is received by MM. Prior Period Coverage (PPC) expenses are only covered under the transplant reinsurance case types.

II. Determination of Benefits

For members diagnosed with Hemophilia, von Willebrand's Disease, Gaucher's Disease, or members receiving one of the covered biotech drugs, Contractors' clinical staff must review the medical documentation to ensure the member's condition meets the criteria for catastrophic reinsurance. If the criteria are met, the Contractor must submit a letter requesting reinsurance to the MM within thirty (30) days of:

- (a) initial diagnosis,
- (b) enrollment with the Contractor, and/or
- (c) beginning of each contract year.

• Catastrophic Reinsurance CRS Coverage Matrix

Case Type	Case Type Description	Hemophilia	von Wilebrand	Gaucher's Disease
CFI	CRS Fully Integrated (010115)	Yes	Yes	Yes
CPA	CRS Partially Integrated ACUTE (010145)	Yes	Yes	Yes
CPB	CRS Partially Integrated Behavioral Health (99125)	No	No	Yes
CRS	CRS ONLY (99135)	No	No	Yes

Process for Requesting Reinsurance Case Creation

The Contractor must submit the "Request for Catastrophic Reinsurance Form Letter", located on the AHCCCS website, to the MM in order to secure catastrophic reinsurance. (See link below)

For newly diagnosed or newly enrolled members with the Contractors, the Contractor must submit the "Request for Catastrophic Reinsurance Form Letter" and the medical documentation within 30 days of the initial diagnosis or enrollment with the Contractor.

For continuation of previously approved catastrophic reinsurance, the Contractor must submit the request form within 30 days of the start of the contract year. MM will use the previously submitted medical information as proof of diagnosis.



@AHCCCS Website- Click on 'Request for Catastrophic Reinsurance':

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/RequestCatastrophicReinsurance.doc>

Note – **END DATE**: If the member's AHCCCS eligibility has an end date, then the catastrophic reinsurance will be approved only for the period of eligibility. **The Contractor is responsible for tracking the end date of the case and if the member's eligibility is extended, the Contractor must submit the "Request for Catastrophic Reinsurance Form Letter" to extend reinsurance. Catastrophic reinsurance will be retrospectively provided for a maximum of 30 days from the date the request is received by MM.**

HEMOPHILIA

For members diagnosed with hemophilia, all medically necessary covered services provided during the contract year shall be eligible for reimbursement. Adjudicated encounters for services provided to enrolled members with a diagnosis of hemophilia will be used to determine reinsurance reimbursement.

AHCCCS maintains a specialty contract for blood clotting factor medications. The Contractor may access anti-hemophilic agents and related pharmaceutical services for hemophilia or von Willebrand's under the terms and conditions of the specialty contract. In that instance, the Contractor is the authorizing payer. A Contractor may use the AHCCCS contract or contract with a provider of its choice. The Contractor will be reimbursed at 85% of the lesser of the AHCCCS contracted rate or the Contractor paid amount for hemophilia blood clotting factor. For services or pharmaceuticals, in the instances in which AHCCCS has specialty contracts or legislation and/or policy that limits the allowable reimbursement, the amount to be used in the computation of reinsurance will be the lesser of the contracted/mandated amount or the Contractor paid amount. The specialty contract bases the rates for factor on 340B pricing. The 340B pricing is set on a quarterly basis and serves as the AHCCCS contracted rate for all reinsurance. These rates are updated within 30 days of the close of each calendar quarter and are posted on the AHCCCS website at the following link:



AHCCCS Website link to AHCCCS Contracted Rate - Hemophilia

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/hemophiliarates.html>

von WILLEBRAND'S DISEASE

For members diagnosed with von Willebrand's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement. Adjudicated encounters for services provided to enrolled members with a diagnosis of von Willebrand's Disease will be used to determine reinsurance reimbursement. Von Willebrand's Disease reinsurance coverage is based on the following:

Von Willebrand's Disease reinsurance coverage is based on the following:

- Type 1 and Type 2A must not respond to desmopressin (DDAVP);
- Type 2B, Type 2M and Type 2N are eligible based on the diagnoses only;
- Type 3 is eligible based on the diagnosis only.

The Contractor must conduct a review of clinical records to determine the member's type of von Willebrand's Disease and whether or not the member has responded to a DDAVP medication prior to requesting catastrophic reinsurance.

GAUCHER'S DISEASE

All medically necessary covered services provided during the contract year shall be eligible for reimbursement for all members with a diagnosis of Gaucher's Disease Type I. Timely adjudicated encounters for services provided to these enrolled members will be used to determine reinsurance reimbursement.



Members with Gaucher's Disease Type 2 and Type 3 are not eligible for catastrophic reinsurance reimbursement **due to** the limited effect of the enzyme replacement infusions.

BIOTECH DRUGS

Catastrophic reinsurance is available to cover the cost of certain biotech drugs when determined to be medically necessary.

Catastrophic reinsurance biotech drug coverage is only available for the costs of the following drugs:

- | | |
|---------------------------|--------------|
| • Aldurazyme | • Elaprase |
| • Ceprotin | • Acthar Gel |
| • Fabryzyme | • Kuvan |
| • Lumizyme | • Orfadin |
| • Myozyme | • Kalydeco |
| • Juxtapid | • Kynamro |
| • Cinryze ← (Newly added) | |

When a generic equivalent of a biotech drug is available, reinsurance reimbursement will be 85% of the lesser of the biotech drug cost or its generic equivalent unless the generic equivalent is contra-indicated for a specific member.

In the instances in which AHCCCS has specialty contracts, or legislation and/or policy limits the allowable reimbursement, the amount to be used in the computation of reinsurance, will be the lesser of the AHCCCS contracted/mandated amount or the Contractor paid amount.

A Contractor may request that a biotech drug (Biological Modifier) or a drug classified as an orphan drug be reviewed by AHCCCS for reinsurance. The Contractor must send a request in writing to MM. The request must identify the drug and all related information provided by the FDA as to the orphan status or support of the drug as a rarely used medication. The request must include the estimated cost and peer-reviewed published literature that supports the use of the medication. Requests must be submitted no later than ~~May 31st~~ April 15th of each year. Any requests received June 1st or after will be considered for the following reinsurance year.

TERMINATIONS OF PREGNANCY INVOLVING STATE ONLY FUNDS

AHCCCS covers pregnancy termination, involving state only funds, if the pregnancy termination is medically necessary according to an assessment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

- a. Creating a serious physical or mental health problem for the pregnant member
- b. Seriously impairing a bodily function of the pregnant member
- c. Causing dysfunction of a bodily organ or part of the pregnant member
- d. Exacerbating a health problem of the pregnant member, or
- e. Preventing the pregnant member from obtaining treatment for a health problem.

The attending physician must attest that a pregnancy termination has been determined medically necessary by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination (see Exhibit 410-4 of the AHCCCS Medical Policy Manual, Chapter 400, Policy 410 "Maternity Care Services").



AHCCCS Website

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf>

All outpatient medically necessary covered services related to the pregnancy termination, for the date of service only on the day the pregnancy was terminated, will be considered for reinsurance reimbursement at 100% of the lesser of the Contractors paid amount or the AHCCCS Fee Schedule amount. Adjudicated encounters for these covered services provided to enrolled members will be used to determine reinsurance benefits.

HIGH COST BEHAVIORAL HEALTH

Expenditures for members considered to be High Cost Behavioral Health (BEH) will also be considered for catastrophic reinsurance reimbursement. BEH reinsurance only applies to members enrolled in the ALTCS program prior to October 1, 2007. Placement into an institutional or HCBS setting for these members must be approved in writing by MM, in order for the Contractor to qualify for reinsurance reimbursement. BEH Reinsurance covers services provided in the institutional or HCBS settings.

If the Contractor believes that a member who has been approved for BEH reinsurance continues to require a specialized treatment program and placement, the Contractor may submit a reauthorization request for continued reinsurance reimbursement. The reauthorization request

and supporting documentation (described below) must be submitted and received by MM no later than 10 business days prior to the expiration of the current approval. Failure to comply with the 10 business day timeframe or the documentation requirements may result in a denial of additional reinsurance reimbursement.

Authorizations are typically for twelve (12) months, but may be authorized for a shorter time period based upon the individual case. The requests must include the supporting documentation as described in Chapter 1600 of the AHCCCS Medical Policy Manual (AMPM).

For ALTCS behavioral health members, medically necessary covered services provided during the contract year may be eligible for reimbursement. Adjudicated encounters for covered services provided to enrolled members with significant behavioral management problems will be used to determine reimbursement. Reinsurance coverage will be based on documentation substantiating the member has been placed in the least restrictive treatment setting to safely manage the member's needs.

III. Deductibles

<i>Case Type</i>	<i>Deductible</i>	<i>Coinsurance</i>
Hemophilia	\$0	85%
Von Willebrand's	\$0	85%
Gaucher's Disease	\$0	85%
Biotech Drugs	\$0	85%
State Only Terminations	\$0	100%
Behavioral Health	\$0	75%

Chapter Six: Other Reinsurance Reimbursement in Special Cases

For all reinsurance case types **other than transplants**, Contractors will be reimbursed 100% for all medically necessary reinsurance covered expenses provided in a reinsurance contract year, after the reinsurance case total value meets or exceeds \$650,000. The \$650,000 figure represents total health plan paid amount including the deductible. Once this level is met, the Contractor must notify, via email, the AHCCCS Reinsurance Supervisor to create the following case type:

- Catastrophic Regular Acute (CRA) and/or Catastrophic Hemophilia (CHM), **or**
- Catastrophic ALTCS (CLT) or Catastrophic Regular CRS (CRC) case and receive enhanced reinsurance reimbursement.

Notification to the AHCCCS Reinsurance Supervisor must include:

- Request to create the CRA, CHM, CLT or CRC case **and**
- List of encounters (by form type **and** in numerical order) that are to be transferred to the CRA, CHM, CLT or CRC case.

Failure to notify

[1] Failure to notify AHCCCS of a request for another case type **or** [2] Failure to notify the reinsurance unit of encounters that should be transferred **or** [3] Failure to adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters and the other catastrophic case for 100% reimbursement.

Chapter Seven: Transplants

I. Eligibility

Transplant reinsurance coverage is available to partially reimburse Contractors for the cost of care for an enrolled member who meets transplant reinsurance criteria specified in the AMPM, Chapter 300, Policy 310-DD. The link to the policy is:

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf>

Prior Period Coverage (PPC) expenses are only covered under transplant reinsurance case types. Transplant reinsurance is not available for members who have an alternate payer, e.g. Medicare or TPL. Transplant reinsurance is not available to CRS Only. CRS is financially responsible for transplants when the transplant is secondary to a CRS-covered condition and the member is enrolled with CRS Only to manage the CRS condition. CRS is then eligible for regular reinsurance.

Kidney transplants (excluding FFS members), bone grafts, and cornea transplantation services do not qualify for transplant reinsurance coverage, but may qualify under the regular reinsurance program (as described in Chapters 2 and 3 of this manual). If it is determined by AHCCCS that a transplant does not meet AHCCCS criteria for the transplant, it will **not** be considered for any reinsurance coverage, including regular reinsurance coverage.

AHCCCS establishes transplant contracts for FFS members and makes the contracts available to its Contractors. Most Contractors use the AHCCCS contracts, but are not required to do so and may alternatively contract with a transplant facility of its choice. Should a Contractor decide not to utilize the AHCCCS transplant contract, AHCCCS will not be involved with negotiated payment rates and contract terms between the provider and the Contractor. When an AHCCCS specialty contract is utilized, the Contractor is the authorizing payer. The Contractor is responsible for prior authorization, care coordination, and reimbursement for all components covered under the contract. A Contractor utilizing the contract must comply with the terms and conditions of the contract. For services that qualify for reinsurance coverage, the Contractor will be reimbursed using the lesser of the AHCCCS contracted rate or the Contractor paid amount for the transplant components. The contracts are not subject to quick pay discounts or interest. The transplant contract rates are updated annually and posted on the AHCCCS web site at:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transplantrates.html>

The contracted rates are comprised of components (stages) at a fixed price for each component. The Contractor may reference the transplant contract for further details. The contract is available on the AHCCCS website at the following link:

<https://www.azahcccs.gov/Resources/Downloads/Solicitations/Open/RFPs/YH13-0008/YH13-0008TransplantationServices.pdf>

In general, the components are defined as follows:

- Outpatient transplant evaluation
- Donor search and/or harvesting of the donor cells for stem cell transplants
- Preparation and transplant
- Post-transplant care (Days 1 – 30 and Days 31 – 60)



@AHCCCS Website – ‘Reinsurance Transplant Case key Entry Instructions’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/ReinsuranceTransplantKeyInstructions.pdf>

AHCCCS website hyperlink: AHCCCS Transition to DRG-based Payment

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html>

When the post-transplant inpatient care is continuous (from the date of the prep and transplant component) and exceeds 10 days for kidney transplants and 60 days for all other case types, the following processing rules apply:

- The claim/encounter for the inpatient stay for day 11+ for kidney transplants and day 61+ for all other case types will be reimbursed at 75% of the transplant per diem rate less the deductible.
- The claim/encounter for the inpatient stay for day 11+ for kidney transplants and day 61+ for all other case types will be eligible for outlier reimbursement (not to be confused with transplant outlier reimbursement) when the cost threshold is met or exceeded. A worksheet and the instructions for completing the worksheet are available on the AHCCCS website at the following link:



@AHCCCS Website Click on - ‘Day 11+ or 61+ Transplant Component Worksheet/Instructions Example’

https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantComponentWorksheet_InstructionsExample_Effective10-01-2014.xlsx

In order to be eligible for transplant reinsurance reimbursement, a Contractor must notify MM within 30 days of the first component of the transplant. Reinsurance will be retroactively provided for a maximum of 30 days from the date the letter was received by AHCCCS. Upon receipt of the request from the Contractor, MM will approve and activate the transplant reinsurance case.



@AHCCCS Website Click on – ‘Request for Transplant Reinsurance’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/RequestTransplantReinsurance.doc>

Please refer to the Reinsurance Transplant Case Key Entry Instructions Manual for specific details relating to PMMIS case management.



Contractor @AHCCCS Website – ‘Reinsurance Transplant Case key Entry Instructions’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/ReinsuranceTransplantKeyInstructions.pdf>

In addition, Contractors must timely submit clean reinsurance claims (i.e. Transplant Invoice Cover Sheet, UB, HCFA 1500, proof of payment and all other supporting documentation as described in this chapter and or the AMPM) to AHCCCS no later than 15 months from the end date of service for each transplant component in order to receive reinsurance reimbursement. The submission date is the date of receipt by the AHCCCS Administration, DHCM.



@AHCCCS Website –

‘Transplant Stage Invoice **C**over Sheet effective October 1, 2014’

https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantStageInvoiceeCoverSheet_Effective10-01-2014.doc

Failure to comply with either the notification filing requirement or the clean claim submission requirement may result in the denial of reinsurance reimbursement.

Transportation, room, and board are reimbursable to the Contractor at the **AHCCCS allowable rates** for the transplant candidate/recipient, potential donor/donor and, if needed, one adult caregiver.

The Contractor may reference the contract link on page 23. The Contractor must submit a request to AHCCCS Reinsurance Finance on the Transplant Transportation Lodging form found at the link below.



@AHCCCS Website – ‘Transplant Transportation Lodging Form’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantTransportationLodgingForm.doc>



Don't forget about Medicare

Transplant Reinsurance is not available for members who have Medicare Part A or Medicare Part A and B.

Exceptions:

A transplant may be covered under the below circumstances

- If a member has Medicare Part A and has exhausted their Medicare Part A benefit (including lifetime reserve days) during a transplant stage, only that stage and subsequent stages may qualify for reinsurance. If the stage(s) qualify, any payments received from Medicare coverage will be deducted from the reinsurance reimbursement.
- If a member has Medicare Part B only, the case may qualify for Transplant Reinsurance and any payments received from Medicare coverage will be deducted from the reinsurance reimbursement.
- If Medicare does not cover a transplant type based on the member's diagnoses and the transplant type is an AHCCCS covered benefit, the case will qualify for transplant reinsurance.

Important:

If the member chooses not to use their available lifetime reserve days, the stages **will not qualify for reinsurance reimbursement.**

Note: Individuals who qualify for transplant services, but who are later determined ineligible, due to excess income, may qualify for extended eligibility (refer to State Only Transplants Option 1 and Option 2 in Section IV below).

II. Covered Transplants

The AHCCCS Administration, as the single State agency, has the authority under Federal law to determine which transplant procedures, if any, will be reimbursed as covered services for Title XIX adults. As with other AHCCCS-covered services, transplants must be medically necessary, cost effective, federally and State reimbursable. Arizona State regulations specifically address transplant services.

However, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program for individuals under age 21 covers all non-experimental transplants necessary to correct or ameliorate defects, illnesses and physical conditions whether or not the particular transplant is covered by the AHCCCS State Plan.

AHCCCS covers medically necessary transplantation services and related immunosuppressant medications in accordance with Federal and State law and regulations. Please refer to the AMPM, Chapter 300, Policy 310-DD for a complete list of the AHCCCS covered transplants.

Multi-Organ Transplants that are not covered in the AHCCCS Specialty Contracts:

MM may authorize cases that overlap when a second transplant component is started within the timeframe of an established component. Therefore, if a member requires a multi-organ transplant the following billing rules apply:

AHCCCS reinsurance will cover the preparation and transplant components for each organ (when performed separately), and the post-transplant component that provides the Contractor with the highest reimbursement and covers the longest period of time.

If a second covered organ transplant is performed during the post-transplant periods of the first transplant, AHCCCS will prorate the first transplant component and provide reinsurance reimbursement for the surgical component of the second transplant. This component is followed by the initial day 1-30 post-transplant component and the day 31- 60 post-transplant component.

For example: If, on day 15 post-transplant of the first, the determination to conduct the preparation and transplant of another organ is made, day 15 ends the component phase of days 1-30 of the first transplant, and 50% of the 1-30 post-transplant component is paid. Day 16 becomes day 1 of the prep and transplant for the second transplant. Remaining transplant components follow. All applicable notification and claims filing requirements apply.

Process for Transplant Reinsurance Case Creation:

The Contractor's Medical Director is responsible for the timely submission of a written request for reinsurance approval of a covered organ or stem cell transplantation. MM staff will review the submission, consult with the AHCCCS Medical Director as necessary, and inform the Contractor's Medical Director in writing of the approval or denial for transplant reinsurance.

The following steps represent the flow for requesting reinsurance for a transplant case:

- a. The Contractor receives a request for a transplant. The Contractor determines if the transplant type is medically necessary and covered under the AHCCCS State Plan in accordance with the AMPM Chapter 300-Policy 310-DD.
- b. If the Contractor receives a request for transplant that is outside of the AMPM criteria, the Contractor may consult an independent review organization regarding whether or not the requested transplant is considered the standard of care and is medically necessary. If the Contractor determines the transplant request should be authorized, the Contractor will inform MM of the pending decision. MM will discuss the case with the AHCCCS Medical Director who will make the final determination in the approval of transplant reinsurance.
- c. The Contractor then submits a request for transplant reinsurance approval to MM which must be received within thirty (30) days of the initiation of the first transplant component. (See Sample Letter for Request for Transplant Reinsurance located on the AHCCCS website.) The Contractor may initially authorize an evaluation or a search only and subsequently approve or deny the transplant after completion of the evaluation and review of the findings. The Contractor is not required to send an additional notification to AHCCCS via a second letter, but the Contractor must communicate if a transplant has been authorized using the Quarterly Transplant Log. (See link below)
- d. If the Contractor denies the transplant based on medical necessity or coverage criteria, the Contractor shall follow the process for Notices of Action as outlined in the AHCCCS Contractor Operations Manual, Policy 414. No notification to MM is required.
- e. MM will review the request and issue an approval of reinsurance indicating that the case has been approved in the PMMIS system.

Notwithstanding the denial of reinsurance by AHCCCS, the Contractor is responsible for payment of claims for all services approved by the Contractor.



@AHCCCS Website – ‘Quarterly Transplant Log’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/QuarterlyTransplantLog.xlsx>

Process for Ongoing Case Communication via the Transplant Log:

1. The AHCCCS Transplant Log is a contract deliverable and must be submitted to MM and received no later than 15 days after the end of each quarter, e.g. January 15th for the quarter ending December 31st.
2. The AHCCCS Transplant Log serves the purposes of communicating the Contractors' transplant activity on a quarterly basis. It also provides AHCCCS with information that can be aggregated for data analysis.
3. The Transplant Log format cannot be altered prior to submission to AHCCCS. If the Transplant Log is password protected or altered in any way, it will be rejected and considered as a non-submission.
4. The Contractor must highlight in yellow the member's name and the cell(s) that have the information that the Contractor would like to communicate. These cells shall not be highlighted in the next quarterly submission unless there is additional information that the Contractor wants to communicate.
5. Contractors must complete the cells with the following information:
 - a. Name: Member Name (Last, First)
 - b. AHCCCS ID: Member AHCCCS identification number
 - c. Transplant Type: Type of transplant
 - d. Transplant Center: Center where the transplant will take place
 - e. Date of Transplant: The date transplant takes place
 - f. Date of Death: The member's date of death.
 - g. Comments: Dates of service for evaluation and any general comments the Contractor wishes to make. In the case of a TPL where the transplant is not covered or the member has no benefit remaining, these would be noted here.
6. The Transplant Log is cumulative for an entire contract year. The log submitted by October 15 will contain the transplant activity for the previous contract year.
7. The Transplant Log created for a new contract year must have all non-active members removed. This includes any member who expired; members who were removed from the wait list; or members who terminated with the Contractor.

III. Claim (Encounter) Documentation and Timeframes

In order to be considered for reimbursement, Contractors must timely submit clean transplant claims for each stage of the solid organ transplantation or hematopoietic cellular therapy with the documentation described below to the DHCM Reinsurance Unit. Clean claims must be received no later than 15 months from the end date of service for each particular transplant stage. Outlier claims must be submitted no later than fifteen (15) months from the end date of the last completed stage. In order to be considered a clean claim, the complete set of encounters for the particular stage must be adjudicated and determined payable on or before the 15 month timeframe. Approximately forty-five days are necessary for AHCCCS to complete the adjudication process. Therefore, Contractors are advised to submit the encounter file at least 45 days prior to the 15 month deadline to ensure that the adjudication meets the 15 month timeframe. If the Contractor submits the encounter file to AHCCCS less than 45 days before the 15 month timeframe and the adjudication has not been completed by the 15 month deadline, then the claim will be denied for not having achieved clean claim status within the required timeframe. Timeliness of the claim submission for each stage of the transplant will be based on the submission date for the complete set of encounters related to the stage. For example, if the first stage of a transplant ends on August 15, 2008, the claim for this stage must be received by AHCCCS on or before November

15, 2009. The complete set of encounters must be adjudicated on or before November 15, 2009, which means the encounter file should be submitted to AHCCCS no later than noon on October 9, 2009. **Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage**

Encounters must be filed with a CN1 code of 09. If encounters are not submitted with a CN1 code of 09, then the encounter will not associate to the case. The Contractor is required to void and replace the encounter with the correct CN1 code if there is more than 45 days before the 15 timely filing deadline, if there is less than 45 days, then the Contractor must submit a list of the CRNs by form type and in numerical order that must be transferred on a Reinsurance Action Request Form, prior to the 15 month timely filing deadline.

Reinsurance payments will be linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounter submissions must agree (the billed charges and health plan paid amounts on the PMMIS R1115 screen must equal the billed charges and health plan paid amounts on the hard copy documents) with supporting transplant stage claims and/or invoices. Prorated calculations are to be applied only when second organs are transplanted or when a member changes Health Plans, (Health Plan Id # changes) in the middle of a transplant stage. The calculation is based on the number of days used during the stage.

When a transplant stage spans contract years the following processing rules apply:

1. The stage rate that is paid to the facility is the rate in effect based on the end date of the stage
2. It is not necessary to split the encounter between the two contract years however the stage must be split between the two contract years based on the actual dates within the two contract years.
3. A Reinsurance Action Request Form must be submitted identifying the encounter (s) with any dates of service that span contract years. AHCCCS staff will associate/transfer the encounter(s) to the case/stage based on the end date of the stage.



@AHCCCS Website Click on – ‘Reinsurance Action Request Form’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/ReinsuranceActionRequestForm.doc>

Effective October 1, 2014, the transplant evaluation is no longer a contracted billing component. Evaluations completed while a member is an inpatient will be reimbursed reinsurance under regular reinsurance using the APR-DRG payment policies.

Effective October 1, 2015, the transplant evaluation component was added as a billing component for those evaluations completed on an outpatient basis only. The outpatient evaluation component is not eligible for outlier reimbursement.

Evaluations completed while a member is an inpatient will be paid as part of the APR-DRG payment schedule.

When the post-transplant inpatient care is continuous (from the date of the prep and transplant component) and exceeds 10 days for kidney transplants and 60 days for all other case types, the following processing rules apply:

- The claim/encounter for the inpatient stay for day 11+ for kidney transplants and day 61+ for all other case types will be reimbursed at 75% of the transplant per diem rate less the deductible.
- The claim/encounter for the inpatient stay for day 11+ for kidney transplants and day 61+ for all other case types will be eligible for outlier reimbursement (not to be confused with transplant outlier reimbursement) when the cost threshold is met or exceeded. A worksheet and the instructions are available on the AHCCCS website see below.



@AHCCCS Website – ‘Day 11+ or 61+ Transplant Component Worksheet/Instructions Example Instructions’

https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantComponentWorksheet_InstructionsExample_Effective10-01-2014.xlsx

Required Information To Be Included With Transplant Claims:

1. An invoice cover sheet, available on the AHCCCS website, link furnished below, and a copy of the invoice from the facility. Each stage must be identified and include the documentation listed below
2. Hard copy of hospital UB.
3. All appropriate HCFA 1500's submitted by the dates of service for the component (totaled for reference).
4. The Contractor's paid amount must be clearly identified for each component.
5. Proof of payment to the facility.
6. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must agree with the transplant facility's related claims and/or invoices. The total billed charges and health plan paid amounts from the PMMIS R1115 screen must agree to the totals on the hard copies of the claims/invoices submitted. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage.
7. List of all no pay/non allowed and/or denied charges totaled by stage and form type.

Contractors shall send the information stated above and the complete reinsurance claim to: AHCCCS Reinsurance Unit, 701 East Jefferson St., Mail Drop 6100, Phoenix, Arizona 85034.

For all transplant case types, it is critical that Contractors perform timely and complete evaluations to determine whether a particular transplant is medically necessary, is considered the standard of care, and is not considered experimental. An AHCCCS Transplant Consultant is available to assist Contractors in those determinations. If it is determined by AHCCCS that a transplant does not meet criteria for transplant reinsurance coverage, it will **not** be covered under regular reinsurance coverage (previously referred to as "inpatient" reinsurance coverage).

IV. State Only Transplants

Option 1 and Option 2 Transplant Services: Reinsurance coverage for State Only Option 1 and Option 2 members for transplants received at an AHCCCS contracted facility is paid at the lesser of 1) 100% of the AHCCCS contract amount for the transplantation services rendered, or 2) the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 1) 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or 2) the Contractor paid amount,

less the transplant share of cost. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS covered organ transplant, the Contractor shall notify AHCCCS, DHCM, MM as specified in the *AMPM Chapter 300, Policy 310 Attachments A, Extended Eligibility Process/Procedure for Covered Solid Organ And Tissue Transplants*.

Option 1 and Option 2 services only apply to Title XIX members.

Option 1 Non-transplant Reinsurance: All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, (ST1 case type) with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters.

V. Out of State or Non-contracted Transplants

To qualify for reinsurance, AHCCCS must review and approve all requests for services at transplant facilities located outside the state of Arizona prior to the commencement of services. If a Contractor intends to use an out of state non-contracted transplant facility, for a covered transplant, and AHCCCS already holds a contract for that transplant type, the Contractor must obtain prior approval from the AHCCCS Medical Director. If no prior approval is obtained, and the Contractor incurs costs at the out of state facility, those costs will not be eligible for either transplant or regular reinsurance. In addition, those costs will be excluded from any applicable reconciliation calculations. An approved transplant performed out of state at a non-contracted facility will be reimbursed at 85% of the lesser of 1) the in state AHCCCS transplant contracted rate if available, or 2) the health plan paid amount. The AHCCCS Medical Director may approve, on a case-by-case basis, the Contractor's use of a non-contracted transplant facility. Depending on the unique circumstances of each approved out-of-state transplant, AHCCCS Reinsurance unit may consider, on a case-by-case basis, reinsurance coverage at 85% of the Contractor's paid amount for comparable case/component rates.

VI. Outlier Parameters

A transplant case may qualify for outlier coverage when a specified contractual deductible (listed on the transplant rate sheets) is met or exceeded. When submitting a request for outlier consideration the outlier worksheet and a transplant stage invoice cover sheet must accompany the request. Outlier stage is created by Reinsurance Finance. The worksheet is available on the AHCCCS web site furnished below.



@AHCCCS Website – 'Transplant Outlier Template Effective October 1, 2014'

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantOutlierTemplate.xls>

https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantStageInvoiceCoverSheet_Effective10-01-2014.doc

The following information must be sent with the outlier request:

1. Completed Transplant Outlier Worksheet.
2. Copy of mock Outlier UB (should this be the process used) for case dates of service inclusive of the contract year of the transplant case stages currently in PMMIS.
3. Identify the AHCCCS UB CRN.
4. Outlier dates of service that span Contract Years split the dates of service into the two contract years on two separate mock UBs.
5. Outlier claim will reflect a zero pay for the earlier contract year with the Outlier payment reflected on the latest contract year, as reimbursement is based on the end date of the stage.
6. Reinsurance Action Request identifies the mock UB(s) AHCCCS CRN.
7. Transplant stage invoice cover sheet.
8. All completed stage invoices.
9. Proof of payment to the facility.
10. List of all no pay/non allowed and/or non-covered/denied charges totaled by stage and form type.

VII. Split Stages when Contractor enrollment changes

When an AHCCCS transplant recipient changes Contractors during a transplant stage the contracted facility must split the stage charges accordingly ~~and prorate~~ and prorate the transplant contracted stage amount to the two separate Contractors. This would also be the necessary process for the outlier should that provision be allowed by contract as the outlier stage is a total of all services during the transplant dates of service. The Contractors will be responsible for setting up the stages in PMMIS for the appropriate dates of service they are responsible for.

Example

Heart

Billed Charges eligible for Outlier consideration

Contractor XYZ

HRT02 PREP AND TRANSPLANT TBC \$200,000.00

HRT10 OUTLIER Stage is 40% of eligible Outlier TBC

40 % of Outlier would be billed to Contractor XYZ

Contractor ZYX

HRT03 FOLLOW UP CARE 1-30 TBC \$100,000.00

HRT04 FOLLOW UP CARE 31-60 TBC \$200,000.00

TBC \$500,000.00

HRT10 OUTLIER Stage is 60% of eligible Outlier TBC

60% of Outlier would be billed to Contractor ZYX

Chapter Eight: Coordination of Benefits and Third Party Payments

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party.

The two methods used in the coordination of benefits are cost avoidance and post payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq., federal, and state law.

Contractors are required to notify AHCCCS or its authorized representative, within ten (10) business days of the identification of a 1st or 3rd party liability case with known Reinsurance. Failure to comply with the notification requirements may result in those sanctions specified in contract. Should AHCCCS or its authorized representative identify third party recovery payments received by the Contractors that do not comply with the notification requirements in this section the following actions shall occur:

- A. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments may be added to the adjustment.
- B. For closed cases, AHCCCS or its authorized representative shall bill the Contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor’s contingency fee schedule shall be added to the billing.

All Medicare and Third Party payers’ should be billed and the encounter adjudicated through the Contractor’s system prior to submission to AHCCCS. In addition, the Medicare Allowed, Medicare Paid, Third Party Payments and Value Code fields, as applicable, must be completed when the encounter is submitted for Reinsurance consideration.

Chapter Nine: Time Limits for Filing Reinsurance Claims

A claim for reinsurance may be filed for any encounter of an AHCCCS reinsurance covered service. In order to qualify for reinsurance consideration, the reinsurance claim must be filed and must reach clean claim status within the submission timeframes described below. An inpatient reinsurance claim consists of a valid encounter containing the information specified in this manual, policy and contract.

Reinsurance claims for regular reinsurance cases are created automatically by PMMIS once the encounter reaches an adjudicated status through the Encounter System. For all other types of reinsurance claims, however, the Contractor must file a *written* request for reinsurance consideration with the AHCCCS DHCM MM, or the DHCM Reinsurance Unit within the required timeframes as described in this manual, policy and contract.

Claims for reinsurance must be submitted to AHCCCS and must attain a clean status no later than fifteen (15) months from the end date of service.

Exceptions:

- Retro Eligibility Encounters
An exception for claims submission will be made for retro eligibility encounters; the claim for reinsurance must be submitted to the AHCCCS Administration and must attain a clean claim status no later than fifteen (15) months from the **date of eligibility posting**.




- Transplant Encounters
For transplant reinsurance claims, refer to Chapter Six: transplant reinsurance claims must be submitted in clean claim status no later than 15 months from the end date of the particular transplant stage.



- Exception from 15 month timeframe

If a claim that gives rise to a reinsurance claim is the subject of a grievance or appeal proceeding or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal. The Contractor has 90 days from the **date of the final decision in that proceeding/action** to file the reinsurance claim **AND** for the reinsurance claim to **reach clean claim status**.

Date of Final Decision 90 Days



Note that a "clean" claim/encounter is one that has passed all of the Encounter and Reinsurance edits and that can be processed without obtaining additional information from the provider of service, the Contractor, or from a third party. This **does not include** claims under investigation for fraud or abuse or claims under review for medical necessity. With respect to hospital/long term care encounters, "date of service" means the date of discharge.



The fact that an encounter has been approved and adjudicated is separate to whether the encounter qualifies for payment under reinsurance. To qualify for reimbursement under the Reinsurance Program, the encounter must independently meet all criteria, including but not limited to, medical necessity of the service, cost effectiveness of the service, non-experimental nature of the service, dollar thresholds etc...

Chapter Ten: Reimbursement

AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages. Covered amounts in excess of the deductible level shall be reimbursed based upon costs paid by the Contractor, net of interest, penalties, discounts and coinsurance, unless the costs are paid under a sub-capitated arrangement.

In sub-capitated arrangements AHCCCS shall base reimbursement of Reinsurance encounters on the lower of the AHCCCS allowed amount or the reported Health Plan paid amount, net of interest, penalties, discounts and coinsurance. Reimbursement for Regular Reinsurance benefits will be made once each month, subject to the availability of funds.

The following Lessor of Logic has been included to assist in determining the Reinsurance Approved Amount.

❖ Pricing & Lesser of Logic

-Determine the Reinsurance Approved Amount (Pricing)

```
SELECT FIRST  
WHEN SUBCAPITATED-CD = '06' '07'  
  BYPASS 06/07 SUBCAP CD ENC. NOT ELIGIBLE FOR REIN  
  SET APPR-AMT = 0.00.
```

```
WHEN CLM-HP-ID = 010166 (CMDP)  
  DO LESSER-OF-CALC
```

```
WHEN FACTOR  
  DO LESSER-OF-CALC
```

```
WHEN MDC-PAID-AMT > 0  
  DO LESSER-OF-CALC
```

WHEN SUBCAPITATED-CD = '01' OR '02' OR '03' OR '04' OR '12' OR '14'
DO LESSER-OF-CALC

WHEN OTHER (SUBCAPITATED-CD = '00', '05' OR '08')
DO HP-PAID/APPR PRICING

ENDSELECT

(At this point pricing is complete.)

-LESSER-OF-CALC

TPL-AMT = OTH-INS-AMT-1 + OTH-INS-AMT-2.

MDC-AMT = MDC-COIN-AMT + MDC-DED-AMT.

MDC-PAID = MDC-PAID-AMT.

AHCCCS ALLOW = ALLOW-AMT.

TOT-BIL = BIL-AMT.

IF ALLOW-AMT < TOT-BIL
SET APPR-AMT = ALLOW-AMT

ELSE
SET APPR-AMT = TOT-BIL.

IF MDC-APP-AMT > 0.00
AND MDC-PAID-AMT >= 0.00
MDC APP & MDC PD PRESENT, CHECK MDC APP AGAINST CURRENT APPR-AMT

IF MDC-APP-AMT < APPR-AMT
SET APPR = MDC-APP.

SET APPR-AMT = APPR-AMT - MDC-PD.

IF SUBCAP = 01, HP-PAID WILL BE 0.00 (SUBCAPPED PMT ARRANGEMENT)
DON'T LOOK AT HP-PAID

ELSE
IF HP-PAID-AMT < APPR-AMT
SET APPR-AMT = HP-PAID-AMT.

IF HP-APPR-AMT < APPR-AMT
SET APPR-AMT = HP-APPR-AMT.

SUBTRACT TPL AMT...
SET APPR-AMT = APPR-AMT - TPL-AMT.

IF APPR-AMT < 0.00
SET APPR-AMT = 0.00.

```

IF PR-TYP = '02' (Hospital)
AND IHS-CD <> '1' AND '3' (Non-IHS)
AND FORM-TYP = 'I' OR 'O' (Inpatient or Outpatient)

IF CLM-HP-ID = 010166 (DES/CMDP)
DO NOT TAKE DISCOUNT FROM SISTER AGENCY...
SET PRICE-PERCENT = 1.00 (We do not take a discount, set to 100%)
ELSE
LOOKUP DISCOUNT FOR NON-IHS HOSPITALS
IF DISCOUNT FOUND
SET PRICE-PERCENT = 0.99 (We will be paying 99% after the 1% discount.)
ELSE
SET PRICE-PERCENT = 1.00. (We do not take a discount, set to 100%)

```

=====

HP-PAID/APPR PRICING

```

SET APPR-AMT = HP-PAID
SET PRICE-PERCENT = 1.00 (We do not take a discount, set to 100%)

IF INPUT-MODE = 1 (HIPAA 837)
CHECK FOR 225 ADJ-REASON-CD (INTEREST PAYMENT)...
IF 225-ADJ-REASON-CD FOUND
SET HP-PAID = HP-PAID - 225-ADJ-AMT.

IF HP-APPR < HP-PAID
SET APPR-AMT = HP-APPR

```

For services or pharmaceuticals, in the instances in which AHCCCS has Specialty Contracts, or legislation and/or policy limits the allowable reimbursement, the amount to be used in the **computation of reinsurance**, will be **the lesser of the AHCCCS contracted/mandated amount or the Contractor paid amount**. Adjudicated encounters for these covered services provided to enrolled members will be used to determine benefits.



Any final claims which cross over contract years will not be eligible for reinsurance.

AHCCCS will not pay reinsurance on interim claims. The **final claim** submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the **hospital stay do not cross contract years**.

AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

Transplant Days 11+/61+ paid at the per diem rate are not subject to the transplant outlier (prep and transplant through day 60) but are subject to outlier pursuant to the transplant Specialty Contract at an established cost threshold. See the Day 11+/61+ Outlier Worksheet and Instructions located on the AHCCCS website.

Sub capitated and CN1 Codes recognized by reinsurance:

CN1 Indicator Crosswalk to Sub Cap Codes			
CN1	DEFINITION	SUB CAP	DESCRIPTION
Blank		00	No sub capitated payment arrangement. Used to report services paid on a fee-for-service basis. When subscriber exception code is 25, subcap code is 05.
01	Diagnosis Related Group (DRG)	00	Full sub capitation arrangement. Used to report services provided under a fully sub capitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
02	Per Diem	00	Full sub capitation arrangement. Used to report services provided under a fully sub capitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
03	Variable Per Diem	00	Full sub capitation arrangement. Used to report services provided under a fully sub capitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
04	Flat	00	Full sub capitation arrangement. Used to report services provided under a fully sub capitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
05	Capitated	01	Full sub capitation arrangement. Used to report services provided under a fully sub capitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
06	Percent	00	Partial sub capitation arrangement. Used to report services provided by a sub capitated provider that are excluded from the sub capitated payment arrangement. When subscriber exception code is 25 (PMMIS Screen Ri320), subcap code is 05.
09	Other	08	Negotiated settlement. Used to report services that are included in a negotiated settlement, for example, claims paid as part of a grievance settlement, when subscriber exception code is not 25.
09	Other	04	Contracted transplant service. Used to report covered transplant services paid via catastrophic reinsurance, when subscriber exception code is 25 (PMMIS Screen Ri320).
	Identified by Filename	06	Denied claim used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.

Encounter Submission

All reinsurance associated encounters must reach a clean claim status within fifteen months from the end date of service, or date of eligibility posting, whichever is later.

I. Voids

When a void encounter is submitted for a previously paid associated Reinsurance encounter, the reinsurance payment related to the voided encounter will be recouped.

II. Replacements

When a replacement encounter is submitted timely for a previously paid associated Reinsurance encounter and the replaced health plan paid amount is less than the original health plan paid amount, the difference will be recouped.

When a replacement encounter is submitted timely for a previously paid associated Reinsurance encounter and the replaced health plan paid amount is greater than the original health plan paid amount, the additional amount will be paid **if** the replacement encounter was adjudicated **and** reached approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.

- ❖ Replacement Encounter
 - Timely submission
 - Health Plan Paid amount is greater than on the original Health Plan Paid amount
 - Replacement encounter was Adjudicated - **AND** -
 - Replacement encounter reached Approved Status (CLM STAT 31)

Result → Any additional reinsurance payment due will be paid.

When a replacement encounter is submitted timely for a previously paid associated Reinsurance encounter and the replaced health plan paid amount is greater than the original health plan paid amount, but the replacement encounter was not adjudicated **and** did not reach approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later within the same encounter cycle then the original health plan paid amount will be recouped.

- ❖ Replacement Encounter
 - Timely submission
 - Health Plan Paid amount is greater than on the original Health Plan Paid amount
 - Replacement encounter was not Adjudicated - **AND** -
 - Replacement encounter did not reach Approved Status (CLM STAT 31)
 - Within the SAME ENCOUNTER CYCLE

Result → Original Health Plan Paid Amount will be recouped.

When a replacement encounter is **not** submitted timely, **and** does **not** adjudicate to encounter approved status (CLM STAT 31) within 15 months from the end date of service, or date of eligibility posting, whichever is later, within the same encounter cycle it was submitted, and 1) the original encounter was never associated to a Reinsurance case; or 2) the original encounter associated to a Reinsurance case but never reached pay status (PY); or 3) the original encounter has a previous reinsurance paid amount of zero (\$0.00), the replacement encounter will be subject to the reinsurance timely filing limits edits H583 REINSURANCE CLAIM RECEIVED MORE THAN 15 MONTHS AFTER END DOS or H584 REINSURANCE CLAIM RECEIVED MORE THAN 15 MONTHS AFTER ELIG POSTING.

- ❖ Replacement Encounter
 - Not submitted Timely
 - Replacement encounter did not Adjudicated - **AND** -
 - Replacement encounter did not reached Approved Status (CLM STAT 31)
 - Within the SAME ENCOUNTER CYCLE
 - Original encounter (encounter identified on the 837 & NCPDP) Never associated to the case -**OR-**
 - Original encounter (encounter identified on the 837 & NCPDP) Never reached "PY" -**OR-**
 - Original encounter (encounter identified on the 837 & NCPDP) Reinsurance Paid Amount = \$0.

Result→ Replacement encounter will be subject to:
[1] Timely Filing Edits
Edit H583 -or- Edit H584

❖ Replacement Encounter

- Not submitted Timely
- Replacement encounter did not Adjudicated - **AND** -
- Replacement encounter did not reach Approved Status (CLM STAT 31)
- Within the SAME ENCOUNTER CYCLE
- Original encounter (encounter identified on the 837 & NCPDP)
Reinsurance Paid Amount > \$0.

Result→ Original Health Plan Paid Amount will be recouped



When it comes to the topic of Replacement Encounters it is a TWO-STEP Process!

- First step
The Original Health Plan Paid Amount will be RECOUPED. **-THEN-**
- Second step
The Replacement Encounter transaction/process

III. New Day

When a new encounter (not a replacement encounter) is submitted for a previously voided encounter, the new encounter is considered a “new day” encounter and subject to the timely filing rules (stated above) when associated to a reinsurance case (i.e. the Reinsurance system will recoup all reinsurance payments made related to the voided encounter. The reinsurance system will then calculate the timely filing limits on the new day encounter of 15 months from end date of service or date of eligibility posting whichever is later, regardless of when the original encounter was adjudicated).

IV. Claim Dispute/Hearing Director’s Decisions

Encounters for reinsurance claims that have passed the fifteen month deadline and are being adjusted due to a grievance or appeal decision must be submitted and pass all encounter and reinsurance edits within 90 calendar days of the date of the final claim dispute decision or hearing decision, or Director’s decision, or other legal action/proceeding whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss of any related reinsurance dollars.

Chapter Eleven: Administrative Dispute Process

Contractors must follow the AHCCCS reinsurance submission processes described in contract, policy and this manual in order for encounters to be reviewed for potential reinsurance payment. If a Contractor has exhausted the reinsurance refiling/reconsideration processes and still disagrees with an action taken regarding a reinsurance claim, the Contractor may file an administrative dispute concerning the payment, denial, or recoupment of a reinsurance claim.

In order for the administrative dispute to be considered by the AHCCCS Administration, the administrative dispute must be **TIMELY** filed by the Contractor. To be timely filed, the administrative dispute must be **RECEIVED** by the AHCCCS Administration no later than 60 days from the remit associated with the Reinsurance Case Summary Report containing the original payment, denial, or recoupment of a timely submitted reinsurance claim. Detailed information regarding the individual reinsurance claims may be found in the monthly Reinsurance Case Summary Report which is received by Contractors in advance of the remit.

All administrative disputes must be in writing and must state the factual and legal basis explaining why the Contractor believes the payment, denial, or recoupment to be incorrect. All administrative disputes must be directed to:

AHCCCS Administration
AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P. O. Box 25520
Phoenix, AZ, 85002

In order for a service and the corresponding encounters to qualify for reinsurance coverage, the service must independently meet criteria for coverage of reinsurance based on consideration of **all** relevant information and documentation. A Hearing Decision which determines that a Contractor must reimburse a particular medical service does not, in and of itself, establish that the service qualifies for reinsurance coverage, under catastrophic, behavioral health, transplant or regular inpatient reinsurance. Hearing Decisions are based on evidence from the official hearing record which may be limited depending upon the evidence presented by the parties. In contrast, reinsurance coverage determinations are based on evaluation of **all** pertinent information and data, whether or not the information was presented at a hearing. Contractors are prohibited from recouping monies paid to providers for services authorized by the Contractor but which have been subsequently denied reinsurance coverage by AHCCCS. Also, Contractors are prohibited from recouping monies paid to providers for services authorized by the Contractor but which have been subsequently denied reinsurance coverage by AHCCCS.

Quick Reference

CN1 Indicator Crosswalk to Sub Cap Codes			
CN1	DEFINITION	SUB CAP	DESCRIPTION
Blank		00	<ul style="list-style-type: none"> • No sub-capitated payment arrangement • Services: fee-for-service basis. (FFS) • Subscriber Exception code is 25 (PMMIS Screen Ri320), • Sub-Cap code is 05.
01	DRG	00	<ul style="list-style-type: none"> • Full sub-capitation arrangement • Services: Fully sub-capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
02	Per Diem	00	<ul style="list-style-type: none"> • Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
03	Variable Per Diem	00	<ul style="list-style-type: none"> • Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement • Subscriber Exception code is 25 (PMMIS Screen Ri320), • Sub-Cap code is 05.
04	Flat	00	<ul style="list-style-type: none"> • Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
05	Capitated	01	<ul style="list-style-type: none"> • Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber Exception code is 25 (PMMIS Screen Ri320), • Sub-Cap code is 05.
06	Percent	00	<ul style="list-style-type: none"> • Partial Sub-Capitation arrangement • Services: Sub-Capitated provider that's excluded from the Sub-Capitated payment arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
09	Other	08	<ul style="list-style-type: none"> • Negotiated settlement • Services: Negotiated settlement, for example-grievance settlement • Subscriber exception code is 25 (PMMIS Screen Ri320)
09	Other	04	<ul style="list-style-type: none"> • Contracted Transplant Service • Services paid via catastrophic reinsurance • Subscriber exception code is 25 (PMMIS Screen Ri320)
	Identified by Filename	06	<ul style="list-style-type: none"> • Denied claim used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.

Case Type	Deductible	Co-ins
RAC-Acute Contractors	\$25,000	75%
RAC-CMDP Contractor	\$20,000	75%
Catastrophic –Biotech	n/a	85%
Transplant	n/a	85%
Other-High\$	n/a	100%
Hemophilia	n/a	85%
Von Wilebrand's	n/a	85%
Gaucher's	n/a	85%
St Only Termination	n/a	100%
High Cost Behavioral Health	n/a	75%
DES – DDD	\$50,000	n/a
RAC-ALTCS – EPD MC PT.A 0-1,999	\$10,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	\$20,000	75%
RAC-ALTCS – EPD No PT.A 0-1,999	\$20,000	75%
RAC-ALTCS – EPD No PT.A 2,000+	\$30,000	75%
ALTCS - LMO & LRO	\$30,000	75%
ALTCS – LMW & LRW	\$20,000	75%

Case Type	Deductible	Coins	CRS Type
RAC	\$75,000	75%	<ul style="list-style-type: none"> • CRS Fully Integrated 010115 • CRS Partially Integrated – Acute 010145 • CRS Partially Integrated – BH 999125 • CRS ONLY 999135
Catastrophic	n/a	85%	<ul style="list-style-type: none"> • CRS Fully Integrated 010115 • CRS Partially Integrated – Acute 010145 • CRS Partially Integrated – BH (LMTD) 999125 • CRS ONLY (LMTD) 999135
Transplant	Refer to Ch.7	Refer to Ch.7	<ul style="list-style-type: none"> • CRS Fully Integrated 010115 • CRS Partially Integrated – Acute 010145
Other	Refer to Ch.4	Refer to Ch.4	<ul style="list-style-type: none"> • CRS Fully Integrated 010115 • CRS Partially Integrated – Acute 010145 • CRS Partially Integrated – BH 999125 • CRS ONLY 999135

RIRI Contract Year	Contract Year Ending
Yr 33	10/01/14 – 9/30/15
Yr 34	10/01/15 – 9/30/16
Yr 35	10/01/16 – 9/30/17
Yr 36	10/01/17 – 9/30/18
Yr 37	10/01/18 – 9/30/19
Yr 38	10/01/19 – 9/30/20
Yr 39	10/01/20 – 9/30/21



10/01/15 Changes in Contractor Responsibilities for AHCCCS Members Behavioral and Physical Health Services

Contractor Responsibilities (prior to 10/1/15)							
GMH/SA (18+Years)				SMI (18+Years)		Children (0-17 Years)	
NON-DUAL (No Medicare)		DUALS (Medicare & AHCCCS)		Behavioral Health	Physical Health	Behavioral Health	Physical Health
Behavioral Health	Physical Health	Behavioral Health	Physical Health	RBHA*	Acute Plan <i>(outside Maricopa County)</i> RBHA <i>(Maricopa County)*</i>	RBHA	Acute Plan
RBHA	Acute Plan	RBHA	Acute Plan				

*Beginning 4/1/2014 the RBHA, Mercy Maricopa Integrated Care, began serving members in Maricopa County for physical and behavioral health.

Contractor Responsibilities 10/1/2015 and Beyond							
GMH/SA (18+Years)				SMI (18+Years)		Children (0-17 Years)	
NON-DUAL (No Medicare)		DUALS (Medicare & AHCCCS)		Behavioral Health	Physical Health	Behavioral Health	Physical Health
Behavioral Health	Physical Health	Behavioral Health	Physical Health	RBHA	RBHA	RBHA	Acute Plan
RBHA	Acute Plan	Acute Plan	Acute Plan				

- ✓ Dual eligible – An individual that is enrolled in Medicaid and Medicare (D-SNP, Medicare Advantage Plan, Fee-for-Service Medicare)
- ✓ RBHAs as of 10/01/15: Mercy Maricopa Integrated Care (Maricopa County), Health Choice Integrated Care (Apache, Navajo, Mohave, Coconino, Yavapai and Gila Counties), Cenpatco Integrated Care (Cochise, Graham, Greenlee, Yuma, La Paz, Pima, Santa Cruz and Pinal Counties)

More information regarding

- Individuals Covered by Both Medicare and Medicaid (Duals) and
- General Mental Health/Substance Abuse Service Delivery for Duals Enrolled in Acute Health Plans on the AHCCCS website:
<http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx>

Transplant Checklist:

- ❑ Invoice Coversheet
 - ❑ Copy of Invoice from Facility
 - ❑ Stages identified & included in documentation
 - ❑ Copy of UB
 - ❑ Copy of 1500's (by DOS) **TOTALED** for reference
 - ❑ Contractor's PAID AMOUNT identified for each component
 - ❑ Proof of payment to the Facility
 - ❑ Payments equal to Facility Claims/Invoices:
 - Transplant Stages
 - Billed Amounts
 - Health Plan paid Amount
- } Facility Claims or Invoices
- ❑ Total Billed Charges (PMMIS RI 115) = Copy of Claims/Invoices
 - ❑ Health Plan Paid Amounts (PMMIS RI 115) = Copy of Claims/Invoices
 - ❑ List all by [1] Stage and [2] Form Type :
 - No Pay
 - Non Allowed
 - Denied

Outlier Checklist:

- ❑ Invoice Coversheet
- ❑ Completed Transplant Outlier Worksheet.
- ❑ Copy of mock Outlier UB (should this be the process used) for case dates of service inclusive of the contract year of the transplant case stages currently in PMMIS.
- ❑ Identify the AHCCCS UB CRN.
- ❑ Outlier dates of service that span Contract Years split the dates of service into the two contract years on two separate mock UBs.
- ❑ Outlier claim will reflect a zero pay for the earlier contract year with the Outlier payment reflected on the latest contract year, as reimbursement is based on the end date of the stage.
- ❑ Reinsurance Action Request identifies the mock UB(s) AHCCCS CRN.
- ❑ All completed stage invoices.
- ❑ Proof of payment to the facility.
- ❑ List of all no pay/non allowed and/or non-covered/denied charges totaled by stage and form type.

TOOLBOX LINK TO ALL FORMS & INSTRUCTIONS ON AHCCCS WEBSITE



@AHCCCS Website:

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

Let's Talk Medicare

- ❖ Medicare Calculations –
The Reinsurance system DOES NOT calculate the Medicare fields on the Encounter or 837. The data on the 837 is translated in the Encounter system. The Reinsurance data is populated and mapped from the fields in the Encounter system. **If**, there are issues regarding how the Contractor submits Medicare amounts on the 837 and its translation to the Encounter then the Contractor must address these issues with the AHCCCS Encounter Unit.
- ❖ PMMIS' view of Medicare –
The Encounter System categories Medicare as the type of Medicare appropriate for the stay.

Meaning, if the Encounter is Form type I then the Encounter System reads the Medicare Field as Medicare Pt A dollars. If the Encounter is Form type A then the Encounter System reads the Medicare Field as Medicare Pt B dollars.

Scenario Examples:

- If the member has only Medicare Pt B and the encounter is for an inpatient stay, then on the encounter the Medicare Pt B dollars should be placed under Other Coverage.
- If the member has only Medicare Pt B and the encounter is for a doctor visit, then on the encounter the Medicare Pt B dollars should be placed under Medicare Coverage

Form Type	Type of Medicare	Field on Encounter
I	Medicare Pt A	Medicare
	Medicare Pt B	Other Insurance
A	Medicare Pt A	Does Not Apply
	Medicare Pt B	Medicare
O	Medicare Pt A	Does Not Apply
	Medicare Pt B	Medicare

- *What Happens When?*
Contractor has an encounter(s) that value over the deductible and the member has Medicare but no case is created. What should the Contract do? Answer: Issues regarding how Medicare is reported

need to be addressed with the AHCCCS Encounters Unit. Because the encounter(s) has not entered into the Reinsurance System the Reinsurance Compliance Auditor cannot assist in this matter.

❖ Medicare Lesser of Logic –

- The Medicare copay, coinsurance or deductible, **or**
- The difference between the Contractor's contracted rate and the Medicare paid amount.



@AHCCCS Website:

<http://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/200/201.pdf>

❖ Edit A510 –
Medicare Deductible and Coinsurance Exceeds Allowed Amount

- Reinsurance Internal Pend –

Medicare Deductible Amount
+ Medicare Coinsurance
Amount > AHCCCS Allowed Amount

- Approval/Denial of CRN is the decision of the Reinsurance Compliance Auditor.



TR: RI205 ACT: I AHCCCS - REINSURANCE USER-ID: 5R7 06/09/15
NTR: RI FORM 1500 07:22:12
EDIT/AUDIT CYCLE COMPLETE RI21L205

CRN: 12345 PRR CRN: RI#: R39000456 PA#:
PR ID: NPI: NAME: PR TYP: 08
RCP ID: DOB: 08/17/1950 SEX: M DOS: 01/02/2014 - 01/02/2014
AHC ID: NAME: Member
ENRL ID: HP: Contractor XYZ TSN: CVG: LMO MODE: 1 INVC #:
PAT ACCT: MED REC NO:

BILLED CHRG:	43.00	UNITS:	1.000	UNT/MEA:	UN	POS:	21
MDC APP:	9.27	PROC:	71010	MOD:	26	EMG:	
MDC PAID:	0.00	ICD9 DX:	793.19		780.60	NDC:	
MDC DEDUCT:	9.27	PRCS LOC:	78	LOC DATE:	02/17/2014		
MDC COIN:	0.00	CLM STA:	31	STA DATE:	02/16/2014		
OTH INS PD:		MDC CVG:	B	CN1 CD:	06	SUB CAP:	00
HP APPR:	6.06	PAY 1:	CFE	PAY 2:	MD	COS:	13
HP PAID:	6.06	PCT 1:	1.0000	PCT 2:	0.3749		
AHC ALLOW:	7.57	CTRT:	J	IHS:	4	LTC:	2
AHC VALUE:	7.57	CATG IND:	Y	CAP RATE:	2200		
		ELIG KEY:	140	BEN CAT:			

COMMENTS:
PF: 1=HLP 2=RTN 3=CLR 4=OVR 5=PRI 6=COP 7=PYR 8=ADJ 9=CNF 10=263 11=261 12=ESC
18=CCI 23=NDC