



Arizona Health Care Cost Containment System Reinsurance Processing Manual

Effective 10/01/2013



Reinsurance Processing Manual

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Chapter One: General Information

I. Introduction

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's health care program for the indigent and medically needy, offers Reinsurance as a stop-loss mechanism to provide contractors with partial reimbursement for specified contract service costs incurred by a member. 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.

This Manual describes the types of reinsurance available to contractors and contains information about covered services, billing procedures and reimbursement policies related to reinsurance cases.

Due dates listed in this manual means due by 5:00 p.m. on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

Please reference the AHCCCS Website at <http://www.azahcccs.gov> for a copy of this manual.

II. Contact Information

AHCCCS Reinsurance Finance	602-417-4539 602-417-4658 602-417-4180 602-417-4138	Fax 602-417-4725
AHCCCS Medical Management	602-417-4086 (Unit Administrative Assistant) 602-417-4204 602-417-4122 602-417-4579 602-417-4097	Fax 602-417-4276
ALTCS Case Management	602-417-4302	Fax 602-417-4855

III. Definitions/Acronyms

AAIHP	American Indian Health Program is an acute care fee-for-service program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Services (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.
ADHS	Arizona Department of Health Services



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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.
BEHAVIORAL HEALTH SERVICES	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	The drugs covered are Aldurazyme, Fabryzyme, Lumizyme, Myozyme, and Elaprase and Ceprotin. Ceprotin was added effective 10/01/2008, and Lumizyme and Myozyme were added effective 10/01/2011. Acthar Gel, Kuvan, and Orfadin are only covered under CRS in addition to Aldurazyme, Fabryzyme, Lumizyme, Myozyme, and Elaprase and Ceprotin and are not covered under Acute or ALTCS. Acthar Gel was added to the list of biotech drugs for CRS with an effective date of 10/01/2011. Effective 10/01/2011, Cerazyme is no longer covered under the biotech drug case type but is covered for Gaucher's Disease under the GCC case type.
CASE	A record comprised of one or more adjudicated encounter(s)
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



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subcontracts with providers, in conformance with contractual requirements, AHCCCS Statutes and Rules, and Federal law and regulations.

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..
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.
ECF	Extended Care Facility
GAUCHER'S DISEASE	An inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulate in the spleen, liver, bone marrow and, in rare cases, the brain.
HEMOPHILIA	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
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	Reinsurance
RTC	Residential Treatment Center



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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
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
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.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act.
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.

Reinsurance case types have been eliminated from the list of definitions and acronyms, individual case types, as well as the begin and end dates for the case types can be located in PMMIS reference menu, screen RF776.



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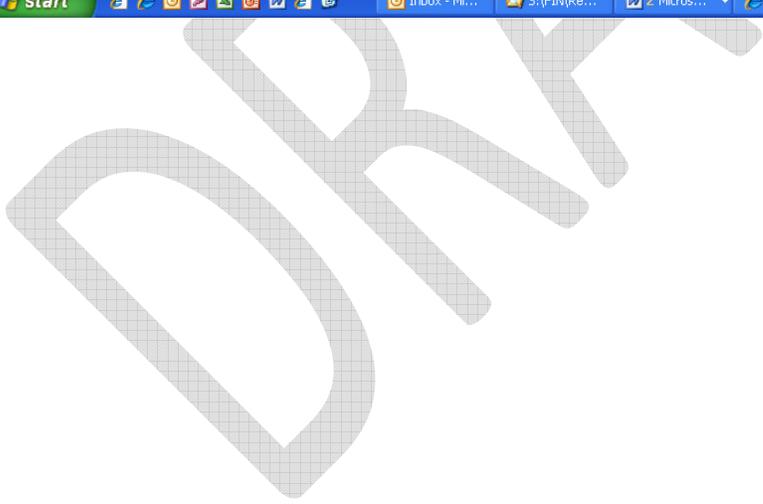
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92. REVENUE CODES TO BILL TYPES	(RF774)	XX	
93. REVENUE CODES TO PROCEDURE CODES	(RF773)	XX	
94. RF771 CODE TYPES	(RF742)	T2	RF742
95. RF771 SERVICE TYPES	(RF798)	T1	RF798
96. RI - CONTRACT YEAR	(RF777)	D2	CTRTY
97. RI - RI CASE STAGE STATUS	(RF784)	T2	RISTA
98. RI - RI CASE TYPE	(RF776)	T3	RICTP
99. RI - RI CATEGORY	(RF790)	T3	RF790
100. RI - RI COVERAGE	(RF745)	T1	RICOV
101. RI - RI COVERAGE TYPE	(RF791)	T3	RF791
102. RI - RI ENCOUNTER STATUS	(RF779)	T2	RIENC
103. RI - RI ENRL CATEGORY BY CONTRACT TYPE	(RF782)	T4	RIENR
104. RI - RI HEALTH PLAN SPECIAL PROCESS	(RF780)	T1	RISPP
105. RI - RI METRO COUNTY	(RF781)	T2	RICTY

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Chapter Two: Acute 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 SOBRA Family Planning, 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.

II. Determination of 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. PPC inpatient expenses are not covered under the Regular Reinsurance program for any members except as described under catastrophic or transplant 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 of the services covered under Regular Reinsurance:

- Inpatient services provided in an acute care hospital. (Provider Type (PT) 02) 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.
- Skilled Nursing Facility (PT 22) 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.
- Inpatient services provided in an accredited psychiatric hospital as licensed by the Arizona Department of Health Services (ADHS) (PT 71).
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- Care provided in a Medicare certified Institution for Mental Disease (IMD) for individuals over 64 years of age.
- Emergency inpatient behavioral health services (not exceeding 72 hours) which are the financial responsibility of the Acute contractor pursuant to R9-22-210.01.
- 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.

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

Reinsurance Pend Report RI91L205
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.

Reinsurance Remittance Advice Report RI81L310
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, recoupments and denials.

Reinsurance Case Summary Report RI91L105
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.

Reinsurance Case Initiation Report RI91L100
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.

Reinsurance Case Reconciliation Report RI91L315
This report is a summary of case information with a detailed listing of all 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 facilitate reconciliation of the encounter records with the reinsurance records.



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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.

<i>Reinsurance Case Type</i>	<i>Deductible</i>	<i>Coinsurance</i>
Regular Reinsurance	\$25,000	75%
Catastrophic Reinsurance	NA	85%
Transplant Reinsurance	NA	85%
Other Reinsurance	Refer to chapter 7 of this manual	Refer to chapter 7 of this manual

Annual deductible levels apply to all members except for State Only Transplant and SOBRA Family Planning Extension Program members.

Beginning October 1, 2014, and annually thereafter, the regular reinsurance deductible levels above may increase by \$5,000.



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Chapter Three: ALTCS Contractors Regular EPD Reinsurance

I. Eligibility

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.

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 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 catastrophic or transplant 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.



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Prospective Reinsurance

<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.

Beginning October 1, 2014, and annually thereafter, each of the deductible levels above may increase by \$5,000.



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Chapter Four: ALTCS Contractors DDD Regular Reinsurance

I. Eligibility

Regular reinsurance (DES case type) is available to partially reimburse the contractors 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 \$100,000 established as of October 1st of each contract year.

IV. Catastrophic Reinsurance

Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. In addition, all medically necessary covered services provided during the contract year shall be eligible for catastrophic reinsurance reimbursement for all members with a diagnosis of Hemophilia, von Willebrand's and Gaucher's Disease classified as Type I under the catastrophic reinsurance program. Please refer to chapter six of this manual for the requirements for reimbursement for catastrophic reinsurance as well as a list of the biotech drugs covered under catastrophic reinsurance for the ALTCS program

V. Other

For all DD reinsurance cases contractors will be reimbursed 100% for all medically necessary reinsurance covered expenses provided in a contract year, after the reinsurance case total value meets or exceeds \$650,000. Once this level is met, the contractor must notify, via email, the AHCCCS Reinsurance Supervisor in order to create the case (DDC) and receive enhanced reinsurance benefits. Notification to the AHCCCS Reinsurance Supervisor must include the request to create the case and the list of encounters (by form type and in numerical order) that are to be transferred to the case. Once the case has been created, it is the contractors' responsibility, if necessary, to split the encounters to associate to the newly created case. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters for 100% reimbursement.



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Chapter Five: 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:

- CFI - CRS Fully Integrated
- CPA – CRS Partially Integrated – Acute
- CPB – CRS Partially Integrated – Behavioral Health
- CRS – CRS Only

III. Deductibles

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

<i>Reinsurance Case Type</i>	<i>Deductible</i>	<i>Coinsurance</i>	<i>Coverage Type</i>
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



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			(limited applicability – see below) CRS Only (limited applicability – see below)
Transplant Reinsurance	Refer to chapter 8 of this manual	Refer to chapter 8 of this manual	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 subject to change by AHCCCS during the term of this contract. Any change in deductible level will have a corresponding impact on capitation rates.

Beginning October 1, 2014, and annually thereafter, the deductible level above may increase by \$5,000.

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..

IV. Catastrophic Reinsurance

Catastrophic reinsurance is available to cover the cost of certain biotech drugs (for the CRS program the case type is BIC) when medically necessary. In addition, all medically necessary covered services provided during the contract year shall be eligible for catastrophic reinsurance reimbursement for all members with a diagnosis of Gaucher's Disease classified as Type I under the catastrophic reinsurance program. Please refer to chapter six of this manual for the requirements for reimbursement for catastrophic reinsurance as well as a list of the biotech drugs covered under catastrophic reinsurance for the CRS program.

Note: Hemophilia and von Willebrand's Disease are not CRS covered conditions; therefore no catastrophic reinsurance is available for these conditions under the CRS Partially Integrated – Behavioral Health and CRS Only coverage types.

V. Other

For all CRS reinsurance cases, the contractor will be reimbursed 100% for all medically necessary reinsurance covered expenses provided in a contract year, after the reinsurance case total value meets or exceeds \$650,000. Once this level is met, the contractor must notify, via email, the AHCCCS Reinsurance Supervisor in order to create the new case (CRC) and receive enhanced reinsurance benefits. Notification to the AHCCCS



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Reinsurance Supervisor must include the request to create the case and the list of encounters (by form type and in numerical order) that are to be transferred to the case. Once the case has been created, it is the contractors' responsibility, if necessary, to split the encounters to associate to the newly created case. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters for 100% reimbursement.

Refer to chapters ten and eleven of this manual for additional details relating to timely filing and other reimbursement requirements for reinsurance cases.

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Chapter Six: Catastrophic Reinsurance

I. Eligibility

Catastrophic Reinsurance is available to partially reimburse the contractor for the cost of care for an enrolled member which is associated with certain medical diagnoses, specific biotech drugs, pregnancy terminations, and high cost behavioral health conditions as described below and in the Medical Policy Manual posted on the AHCCCS website.

To be evaluated by AHCCCS as a catastrophic reinsurance case, contractors must timely provide AHCCCS DHCM Medical Management Unit (MMU) with initial notification of the cases identified for catastrophic reinsurance coverage and include specific supporting medical documents as specified below. Failure to timely comply with the notification requirements will result in the denial of reinsurance coverage. Prior Period Coverage (PPC) expenses are only covered under the catastrophic and transplant reinsurance case types.

II. Determination of Benefits

If timely notification is made, limited retro reinsurance coverage is available as discussed below. For members diagnosed with Hemophilia, von Willebrand's members who are non-D-DAVP responders and Gaucher's Disease or members receiving one or more of the covered Biotech drugs, contractors must provide written notice to the MMU within thirty (30) days of

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

If the 30 day written notice is provided, and all other requirements have been met, catastrophic coverage will be provided for a maximum of 30 days retroactive from the date that notification was received by AHCCCS. Failure of the contractor to provide written notice within the 30 day prescribed timeframe shall result in the denial of catastrophic reinsurance coverage. The Director or designee shall determine whether a case is catastrophic based on the following criteria:

- (a) severity of medical condition, including prognosis,
- (b) the average cost or average length of hospitalization and medical care, or both, for the State of Arizona, for the type of case under consideration,
- (c) proof of diagnosis,
- (d) physician orders documenting the medication type for all hemophiliacs and members receiving biotech drugs that have been deemed as covered in contract, policy and this manual.

Note: Hemophilia and von Willebrand's diseases are not covered conditions under the CRS Partially Integrated – Behavioral Health and CRS Only coverage types.



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Process for Requesting Reinsurance Case Creation

Beginning of each contract year: The contractor must submit the “Request for Catastrophic Reinsurance Form Letter” located on the AHCCCS website at the following link: www.azahcccs.gov/commercial/ContractorResources/reinsurance/reinsurance.aspx within 30 days of the start of the contract year for continuing catastrophic reinsurance cases. AHCCCS, MMU will use the previously submitted medical information as proof of diagnosis.

For initial treatment or newly enrolled members with the contractor, the contractor must submit the “Request for Catastrophic Reinsurance Form Letter” and the medical information (as stated previously) as supporting documentation within 30 days of the initial diagnosis or enrollment with the contractor.

Note: If the member’s AHCCCS eligibility has an end date, then the catastrophic reinsurance case will be created with an end date equal to the end date of the member’s 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 the end date on the catastrophic reinsurance case.** Failure of the contractor to provide written notice to extend the end date within the 30 day prescribed timeframe shall result in the denial of catastrophic reinsurance coverage.

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 (ICD9 codes 286.0, 286.1, and 286.2) will be used to determine benefits.

AHCCCS maintains a specialty contract for blood clotting factor medications with Phoenix Children’s Hospital. 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 for members enrolled in their plans. In that instance, the contractor is the authorizing payor. A contractor may use the AHCCCS contract or contract with a provider of their 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 (anti-hemophilic) medications. 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 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 thirty dates of the close of each calendar quarter and are posted on the AHCCCS website at the following link: www.azahcccs.gov/commercial/ProviderBilling/rates/Hemophiliarates.aspx.

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



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disease who are non-D-DAVP responders and dependent on Plasma Factor VIII will be used to determine benefits (with limitations as mentioned above).

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 classified as Type I. Encounters for services provided to these enrolled members therapy will be used to determine benefits.

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 (BIO case type) is only available for the costs of the following drugs: Aldurazyme, Ceprotin, Fabryzyme, Lumizyme, Myozyme, and Elaprase for all contractors. Catastrophic reinsurance biotech drug coverage includes three additional drugs, Acthar Gel, Kuvan and Orfadin for members with CRS conditions in the ALTCS – EPD or CRS (all coverage types) programs.

The biotech drugs covered under catastrophic reinsurance may be reviewed by AHCCCS at the start of each contract year. When a generic equivalent of a biotech drug is available, reinsurance reimbursement for biotech drugs qualifying for reinsurance coverage will be made at 85% of the lesser of the biotech drug cost or its generic equivalent unless the generic equivalent is contra-indicated for a specific member.

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.

A contractor may request that a biotech (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 AHCCCS, Medical Management Unit. 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 used for rare genetic disorders. The request must include the estimated cost and usage of the drug including any ancillary administration fees and the medical documentation that supports the medical condition for which the drug is being used. AHCCCS will review the request and upon acceptance of a complete packet of information render a decision within sixty (60) days which will include the effective date of the coverage if applicable.

TERMINATIONS OF PREGNANCY INVOLVING STATE ONLY FUNDS

AHCCCS covers pregnancy termination, involving state only funds if the pregnancy termination is medically necessary according to the medical judgment 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



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- 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 acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination (see Exhibit 410-1 of the AHCCCS Medical Policy Manual, Chapter 400, Policy 410 "Maternity Care Services").

All outpatient medically necessary covered services related to the pregnancy termination, for dates 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.



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HIGH COST BEHAVIORAL HEALTH

Expenditures for members considered by the DHCM, ALTCS Unit to be High Cost Behavioral Health (BEH) (only applies to members enrolled in the ALTCS program prior to October 1, 2007) will also be considered for catastrophic reinsurance reimbursement using separate guidelines. Placement into an institutional or HCBS setting for these members must be approved in writing by DHCM, ALTCS, Case Management Unit in order for the Program contractor to qualify for Reinsurance reimbursement. The AHCCCS Medical Policy Manual (AMPM), Chapter 1600, Standard IX outlines the specific procedures for BEH Reinsurance requests. BEH Reinsurance will cover the institutional or HCBS setting only.

Effective October 1, 2007, no new High Cost Behavioral Health Reinsurance cases will be approved; only ALTCS members who have been approved for this coverage as of September 30, 2007, will be reviewed for continued Behavioral Health Reinsurance coverage as described below. Members determined by the DHCM, ALTCS, Case Management Unit to meet high-cost Behavioral Health (BEH) criteria will continue to be covered by BEH Reinsurance for their institutional or HCBS setting only.

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 in writing and received by the ALTCS Case Management Unit of the Division of Health Care Management no later than ten 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 six (6) months at a time, but may be for up to twelve (12) months, based upon the individual case. The requests must include the supporting documentation as described in Chapter 1600 of the AHCCCS Medical Policy Manual.

For 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 that the member has been placed in the least restrictive treatment setting to safely manage the member's needs.

Failure to comply with any AHCCCS requirements described in this manual, contract, AHCCCS Medical Policy Manual, Chapter 1600, Standard IX, as described at the following link, <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1600.pdf>, or other materials may result in the denial of Reinsurance reimbursement.



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III. Deductibles

Case Type	Deductible	Coinsurance
Hemophilia	\$0	85%
von Willebrand's	\$0	85%
Gaucher's	\$0	85%
Biotech Drugs	\$0	85%
State Only Terminations	\$0	100%
Behavioral Health	\$0	75%



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Chapter Seven: 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 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 in order to create the Catastrophic Regular Acute (CRA) and/or Catastrophic Hemophilia (CHM), or Catastrophic ALTCS (CLT) or Catastrophic Regular CRS (CRC) case and receive enhanced Reinsurance benefits. Notification to the AHCCCS Reinsurance Supervisor must include the request to create the CRA, CHM, CLT or CRC case and the list of encounters (by form type and in numerical order) that are to be transferred to the CRA, CHM, CLT or CRC case. Once the CRA, CHM, CLT or CRC case has been created, it is the contractors' responsibility, if necessary, to split the encounters to associate to the newly created CRA, CHM, CLT or CRC case. Failure to notify AHCCCS or failure to split and 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.

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Chapter Eight: Transplants

I. Eligibility

Transplant Reinsurance is available to partially reimburse contractors for the cost of care for an enrolled member who meets Transplant Reinsurance criteria and requirements as specified in the AHCCCS Medical Policy Manual, Chapter 300, Standard 310-DD, link is as follows: <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf>. Prior Period Coverage (PPC) expenses are only covered under the catastrophic and transplant reinsurance case types. Transplant Reinsurance is not available for members who have an alternate payor, e.g. Medicare or TPL. Bone grafts, kidney 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).

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 or for the purposes of research. An AHCCCS Transplant Consultant is available to assist contractors in those determinations. If it is determined by AHCCCS that a transplant (other than bone grafts, kidney and cornea transplantation) does not meet criteria for Transplant Reinsurance coverage, it will **not** be considered for any reinsurance coverage, including Regular Reinsurance coverage.

AHCCCS maintains a specialty contract for covered transplants (with the exception of cornea and bone grafts) with several transplant facilities. The contractor may access these contracts under the terms and conditions of the specialty contract for members enrolled in their plans. When an AHCCCS specialty contract is utilized, the contractor is the authorizing payor, and the contractor is responsible for prior authorization, care coordination, and reimbursement for all components covered under the contract for their members. A contractor utilizing the contract must comply with the terms and conditions of the contract. A contractor may use the AHCCCS contract or, alternatively contract with a provider of its choice. For services which 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 specialty contract rates are updated annually and posted on the AHCCCS web site at:

www.azahcccs.gov/commercial/ProviderBilling/rates/Transplantrates.aspx

The contracted rates are comprised of components (stages) at a fixed price for each component. The contractor may reference the Transplant Contract for further detail as to what is covered under each component, and the contract is available to the contractor upon request to the AHCCCS Medical Management Unit. In general, the components are defined as follows:

- Evaluation (generally not to exceed sixty (60) days)
- Components that comprise the search or harvesting of the donor cells or organs (varies by transplant type)
- Preparation and Transplant of the member
- Post Transplant Care with components defined in specific time frames - not to exceed sixty (60) days after the transplant.



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In order for a case to be evaluated for potential transplant reinsurance coverage, a contractor must provide AHCCCS with timely initial notification of the referral for evaluation for transplant, donor search or any part of the transplant component. When a member is referred for evaluation to a transplant facility for an AHCCCS covered transplant, the contractor must notify the DHCM Medical Management Unit in writing within 30 days of referral in order to receive transplant reinsurance benefits for all components. If not received within 30 days of referral, then only those stages with begin dates within 30 days of the date of the letter will be covered. Transplant reinsurance cases are reviewed and activated only by the AHCCCS Medical Management Unit (MMU) upon receipt of a written request from the contractor. The MMU may then approve and activate the transplant reinsurance case provided all medical necessity and coverage criteria are met. A form letter (entitled "Request for Transplant Reinsurance") has been placed on the AHCCCS website at the following link:

www.azahcccs.gov/commercial/ContractorResources/reinsurance/reinsurance.aspx.

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

In addition, contractors must timely submit clean reinsurance claims (i.e. Transplant Invoice Cover Sheet, UB 92, HCFA 1500, proof of payment and all other supporting documentation as described in this chapter and or the AHCCCS Medical Policy Manual) to AHCCCS no later than 15 months from the end date of service for each transplant component in order to receive reinsurance reimbursement. Submission date is the date of receipt by the AHCCCS Administration, Division of Health Care Management.

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

AHCCCS covered transplant related services subsequent to day sixty (60) post transplant are not covered under transplant reinsurance but may be eligible under Regular Reinsurance (as described in Chapters Two and Three of this manual).

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

For adults, organ transplant services are not mandatory covered services under Title XIX. Each State has the discretion to choose whether or not transplants will be available to members. 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. As with other AHCCCS-covered services, transplants must be medically necessary, cost effective, Federally reimbursable 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 non-experimental 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 AHCCCS Medical Policy Manual, Chapter 300, Standard 310-DD for a complete list of the AHCCCS covered transplants.



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

The Medical Management Unit will not 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 one evaluation, both actual transplant components (when performed separately), and the organ's 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 phase and the day 31- 60 post transplant component. For example: If, on day 15 post transplant of the first transplant (50% of the way through the day 1-30 phase), the determination to conduct the next prep and transplant 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 phase 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.

Other special circumstances:

The member receives a kidney and a simultaneous liver: Reinsurance reimbursement is limited to the terms of the liver transplant and all applicable notification and claims filing requirements apply. Reinsurance Medical Management and Finance units must be timely notified as the case may need special handling. All applicable notification and claims filing requirements apply.

In the case where the member receives a kidney and within the 10 days post transplant, a liver becomes available, the kidney transplant costs may be eligible for regular reinsurance under the applicable requirements until the date of the liver transplant. The liver transplant prep and transplant component is then covered and a post transplant period begins after the liver transplant. Reinsurance reimbursement is limited to the terms of the liver transplant and all applicable notification and claims filing requirements apply.

Process for Transplant Reinsurance Case Creation:

The contractor's Medical Director is responsible for timely submitting to the AHCCCS Medical Management Unit, a written request for reinsurance approval of a covered organ or hematopoietic cell transplantation. The AHCCCS Medical Director or designee will review the submitted documentation, consult with the appropriate outside experts and inform the contractor's Medical Director in writing of the approval or denial of the case under reinsurance.

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

1. 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-Standard 310-DD. The contractor must make the determination using the opinion of transplant experts.
 - a. The contractor shall consult with a transplant expert regarding the transplant authorization request. The contractor may utilize the AHCCCS Specialty Contract for the professional opinion to determine if the member meets the requirements for coverage or the contractor may use its own qualified experts for review of the request when making a determination. If



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the contractor determines the request meets the clinical criteria for coverage the contractor authorizes the transplant. The contractor follows its process for notifying the requesting provider of the determination within the required timeframes for decision determinations (outlined in ACOM Policy 414). The contractor then submits a request for transplant reinsurance case creation to the AHCCCS Medical Management Unit which must be received within thirty (30) days of the referral to the transplant facility by the contractor. (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 evaluation 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. The determination that a transplant meets reinsurance coverage and case creation occur at the time of the contractor's initial reinsurance request to AHCCCS.

- b. 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 ACOM Policy 414. No notification to AHCCCS Medical Management is required. AHCCCS Medical Management may review the denial documentation in the normal course of oversight.
- c. If the contractor's Medical Director or the requesting provider requests an expert in the field to provide an opinion on medical necessity or standard of care, the contractor may use the AHCCCS contract for transplant specialty consultations by contacting the AHCCCS Medical Management Unit.
 - i. If the expert consultation determines that the transplant is contraindicated, does not meet standard of care guidelines as published in the United States or is considered clinical research or experimental as defined in AMPM Chapter 300 Standard 310-DD, then AHCCCS Medical Management will not approve the member for reinsurance coverage, unless the AHCCCS Medical Director has reviewed and approved the reinsurance case based on additional information received by the contractor.
- d. AHCCCS Medical Management will review the request for reinsurance and if the transplant meets all the clinical criteria outlined in the AMPM Chapter 300 Standard 310-DD, will issue an approval of reinsurance indicating that the case has been approved in the PMMIS system.
- e. If the request for reinsurance does not meet the criteria specified in the AMPM Chapter 300 Standard 310-DD, AHCCCS Medical Management will contact the AHCCCS Medical Director for review. The AHCCCS Medical Director may request an independent expert review. If the expert reviewer determines that the transplant is not indicated for the condition/ diagnosis, then AHCCCS Medical Management will issue a denial of reinsurance to the contractor. See c. i above. Notwithstanding the denial of reinsurance by AHCCCS, the contractor is responsible for payment of claims for all approved services as well as all fees associated with experts.

Process for Ongoing Case Communication via the Transplant Log:

1. The AHCCCS Transplant log is a contract deliverable and must be submitted to the AHCCCS Medical Management Unit and received no later than 15 days



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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 format of the transplant log 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. (Reference the contract for penalties for failure to timely submit contract deliverables, varies from Notice to Cure to sanctions.)
4. The contractor must highlight in yellow the member's name and the cell that has 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 is wishing to communicate.
5. The contractor is responsible to confirm that the dates entered into PMMIS match the billing before it is submitted to AHCCCS for payment.
6. The log must be completed for all three worksheet tabs. The first tab is for all Medicaid Reinsurance cases, the second for all TPL/Medicare primary transplant cases, and the third is for kidney transplant cases.
 - a. Tab four contains Transplant Log instructions.
 - b. Tab five contains the drop down box legend.
7. Contractors must complete the cells with the following information:
 - a. Name: Member Name
 - b. AHCCCS ID: Member AHCCCS identification number
 - c. Date of Birth: Member Date of Birth
 - d. Eligibility End Date: Date that eligibility expires if listed in the AHCCCS PMMIS system.
 - e. Type of Transplant: Use the drop down box to select type of transplant. This is the same reinsurance case type that will be set up in PMMIS.
 - f. Transplant Center: Use the drop down box to select the contracted transplant center.
 - g. Date Plan Approved: Date the Contractor approved the evaluation and transplant.
 - h. Evaluation Date Span: The dates during which the evaluation takes place.
 - i. Donor Search Date Span for hematopoietic stem cell transplants (HSCTs): The dates during which the donor search takes place.
 - j. Term Date of Transplant Type: This cell is used to identify when a transplant type is changed, (e.g. from a cadaveric kidney to a living donor kidney or from an allogeneic related hematopoietic transplant type to an allogeneic unrelated hematopoietic transplant type). The contractor would end this row and insert a new row below this line so the member is listed twice and the new information can be entered.



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The contractor shall enter N/A for the transplant date and post period after the type of transplant that will not be performed

- k. Start Date of Transplant: The date(s) during which the prep and transplant take place.
 - l. Post Transplant Date Spans: This relates to Days 1-10 for kidney transplants and Days 1- 60for all other transplants. These dates must correlate to the end date of the transplant and cannot extend past any eligibility termination.
 - m. Date of Death: The member's date of death.
 - n. Comments including TPL: 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.
8. The transplant log is cumulative for an entire contract year. The log submitted by October 15 for the contract dates of October 1 through September 30 will include information on all members with transplant activity during the contract year.
9. 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. Members for whom there are open billing dates must remain on the log.

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



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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 RI115 screen must equal the billed charges and health plan paid amounts on the hard copy documents) with supporting transplant stage claims and/or invoices. Pro-rated calculations are to be applied only when second organs are transplanted or when a member changes Health Plans in the middle of a transplant stage. The calculation is based on the number of days used during the stage.

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. www.azahcccs.gov/commercial/Downloads/Reinsurance/TransplantStageInvoiceCoverSheet.doc
2. Hard copy of hospital UB92.
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 RI115 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 non-covered/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 6600, 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



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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, Division of Health Care Management, Medical Management Unit as specified in the *AMPM Chapter 300, Policy 310 Attachments A, Extended Eligibility Process/Procedure for Covered Solid Organ And Tissue Transplants*.

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 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 transplant facility for a covered transplant and AHCCCS already holds an in state 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.

VI. Outlier Parameters

A transplant case may qualify for outlier coverage when a specified contractual deductible is met or exceeded. When submitting a request for outlier consideration the outlier worksheet must accompany the request. The worksheet is available on the AHCCCS web site furnished below.

www.azahcccs.gov/commercial/Downloads/Reinsurance/TransplantOutlierTemplate.xls

The following information must be sent with the outlier request:

1. All completed stage invoices.
2. Proof of payment to the facility.
3. List of all non-covered/denied charges totaled by stage and form type.



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Chapter Nine: 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. and 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 shall 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.



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Chapter Ten: 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, Medical Management Unit, the DHCM ALTCS Case Management Unit or the DHCM Reinsurance Unit within the required timeframes as described in this manual, policy and contract. Except for retro-eligibility situations, 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. For reinsurance claims regarding 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. 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.

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 unrelated 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.



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Chapter Eleven: 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 subcapitated arrangement. In subcapitated 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. 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.

Subcapitated and CN1 Codes recognized by reinsurance:

CN1 Indicator Crosswalk to Sub Cap Codes			
CN1	DEFINITION	SUB CAP	DESCRIPTION
Blank		00	No subcapitated 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 subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
02	Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
03	Variable Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
04	Flat	00	Full Subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
05	Capitated	01	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
06	Percent	00	Partial subcapitation arrangement. Used to report services provided by a subcapitated provider that are excluded from the subcapitated payment arrangement. When subscriber exception code is 25, 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.
	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.



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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 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, any additional reinsurance payment due will only be paid if the replacement encounter was adjudicated and reached approval should this be approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.

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, 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 and edits H583 REINSURANCE CLAIM RECEIVED MORE THAN 15 MONTHS AFTER END DOS and H584 REINSURANCE CLAIM RECEIVED MORE THAN 15 MONTHS AFTER ELIG POSTING.

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, and does not adjudicate to encounter approved status (CLM STAT 31) in the same encounter cycle it was submitted, any reinsurance payment related to the original encounter will be recouped.

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).

4. 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



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whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss of any related reinsurance dollars.

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Chapter Twelve: 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 either 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.