REINSURANCE HOT NEWS

August 4th, 2014

Save the Date

Encounters Communication

Important Information on Medicare Part B

Only Claims Billing

Save the Date

2014 Annual
Reinsurance Workshop
Wednesday, October 1, 2014

- Mandatory attendance for Reinsurance Analyst's and Transplant Coordinators.
- Send any agenda items you would like addressed during the Workshop by August 15th, 2014.
- Agenda to follow.

Current Agenda Topics

PMMIS Security

Contract Year 33 Changes

Reinsurance Processing Manual
Effective 10/01/2014

Reinsurance & DRG

Transplants

Medicare Part B

07/29/2014

AHCCCS Encounters provided the following communication with directions for submitting Encounters for a member who either has Medicare Part B only or the member has exhausted all of their Medicare Part A coverage. The instructions state; **"AHCCCS will allow the Contractors to void and replace any relevant encounters for open reinsurance contract years ONLY"**. Reinsurance Finance is asking that all related encounters be replaced by the first Encounter cycle in October, 2014. The replacement of a previously submitted encounter must be completed within the same Encounter cycle. Should there be a Reinsurance timely filing deadline issue each will be reviewed on an individual CRN basis as identified by the Contractor.

Important Information on Medicare Part B Only Claims Billing

*******PLEASE FORWARD TO THE APPROPRIATE ENCOUNTER, INFORMATION SYSTEMS AND REINSURANCE PERSONNEL********

July 29, 2014

From Gina Aker:

Contractors,

In October 2011, AHCCCS instructed the Contractors to bill Medicare B Only claims using the example from the attached email. As a result of the calculation, the Contractors reported paid amounts were reduced and the Contractors did not receive the full benefit of the reinsurance payments. AHCCCS has reviewed the logic for processing encounters for either Medicare Part B Only or for a member who has exhausted all of their Medicare Part A coverage and have revised our instructions to ensure the Contractors receive

full benefit of reinsurance payments. **AHCCCS will allow the Contractors to void and replace any relevant encounters for open reinsurance contract years ONLY**. If a Contractor inappropriately alters a reinsurance encounter for a closed contract year, the Contractor will have the reinsurance payments recouped. The revised instructions will be included in the next Encounter Manual revision. If you have any questions please contact me at 602.417.4016.

FW Medicare
Example from the RI M

Institutional Inpatient encounters being submitted by the Contractors for a member who effective only has Medicare Part B Coverage (either Medicare Part B Only or the member has exhausted all of their Medicare Part A coverage) should have the Medicare Part B payment reported using the following segments:

2320/SBR - Other Subscriber Information

2320/CAS - Claim Level Adjustments

2320/AMT – COB Payer Paid Amount

Loop	Element	Description	837 Note	AHCCCS Usage/Expected Value
2320	**SBR**	**OTHER SUBSCRIBER INFORMATION**		
2320	SBR01	Payer Responsibility Sequence Number Code		Expect any value
2320	SBR02	Individual Relationship Code		Expect any value
2320	SBR03	Insured Group or Policy Number		NOT USED BY AHCCCS
2320	SBR04	Other Insured Group Name		NOT USED BY AHCCCS
2320	SBR05	Insurance Type Code		NOT USED
2320	SBR06	Coordination of Benefits Code		NOT USED
2320	SBR07	Yes/No Condition or Response Code		NOT USED
2320	SBR08	Employment Status Code		NOT USED
2320	SBR09	Claim Filing Indicator Code		Expect any value
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**		01/08/13: AHCCCS expects Co-pay amounts to be reported at the 2430/CAS segment for Institutional files.
2320	CAS01	Claim Adjustment Group Code		Expect any value
2320	CAS02	Adjustment Reason Code	Occurrence 1	Expect Adjustment Reason Code

2320	CAS03	Adjustment Amount		Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported Per section 1.4.5 Allowed/Approved Amount is determined as: Prior payer's payment (2320, AMT*D*$) + Total of all patient responsibility adjustment amounts (CAS*PR*RSN CD*$*, CAS03, 06, 09, 12, 15, 18) = Allowed Amount
2320	CAS04	Adjustment Quantity		Expect Adjustment Qty
2320	CAS05	Adjustment Reason Code	Occurrence 2	Expect Adjustment Reason Code
2320	CAS06	Adjustment Amount		Expect Adjustment Amount
2320	CAS07	Adjustment Quantity		Expect Adjustment Qty
2320	CAS08	Adjustment Reason Code	Occurrence 3	Expect Adjustment Reason Code
2320	CAS09	Adjustment Amount		Expect Adjustment Amount
2320	CAS10	Adjustment Quantity		Expect Adjustment Qty
2320	CAS11	Adjustment Reason Code	Occurrence 4	Expect Adjustment Reason Code
2320	CAS12	Adjustment Amount		Expect Adjustment Amount
2320	CAS13	Adjustment Quantity		Expect Adjustment Qty
2320	CAS14	Adjustment Reason Code	Occurrence 5	Expect Adjustment Reason Code
2320	CAS15	Adjustment Amount		Expect Adjustment Amount
2320	CAS16	Adjustment Quantity		Expect Adjustment Qty
2320	CAS17	Adjustment Reason Code	Occurrence 6	Expect Adjustment Reason Code
2320	CAS18	Adjustment Amount		Expect Adjustment Amount
2320	CAS19	Adjustment Quantity		Expect Adjustment Qty
2320	**AMT**	**COB PAYER PAID AMOUNT**		
2320	AMT01	Amount Qualifier Code		Expect 'D'
2320	AMT02	Payer Paid Amount		Expect COB Payer Paid Amount
2320	AMT03	Credit/Debit Flag Code		NOT USED