REINSURANCE HOT NEWS

Follow Up Items from the 2014 Reinsurance Workshop

October 20, 2014

Example of an RI associated Inpatient Encounter that has processed through DRG pricing and has been used to help create the catastrophic over $650,000 case type

Example of Non-covered/Denied/Disallowed Charges Reported on the Transplant Stage Invoice Cover Sheet
Once the regular case meets or exceeds the required $650,000 case total value and the Contractor has appropriately notified the Reinsurance supervisor for a request to create a Catastrophic case (as identified in Chapter Seven of the RI Processing Manual), the CRN will remain associated to the regular case type with an RI Override amount applied. The remaining dollars of the Inpatient encounter that processed through DRG pricing will be “carried over” to the Catastrophic case type and displayed in the “650K PLUS $$:” field.

A. RAC case before CRN is priced – Case Total is 955,262.23 - Deductible of 25,000.00 = Liability of 930,262.23 x RI Percent .75 = Total Payable 697,696.67

| TR: RI120 ACT I | AHCCCS - REINSURANCE | USER-ID: L88 | 10/09/14 |
| CASE NUMBER: R330000004 | PA CASE NO: | |
| CASE TYPE: RAC REGULAR ACUTE REINSURANCE (CYE 07+) | AHCCCS ID: | |
| RECIPIENT: TEST, JACKSON | HEALTH PLAN: | |
| HEALTH PLAN: | DEDUCTIBLE: 25000.00 | |
| HEALTH PLAN: | TTL PAYABLE: 697696.67 | |
| HEALTH PLAN: | TTL RCVRY: 0.00 | |
| HEALTH PLAN: | TTL PREM TX: 0.00 | |
| ALLOWED AMT: 955262.23 | LIABILITY: 930262.23 | |
| CASE TOTAL: 955262.23 | TOTAL PAID: 0.00 | |
| RI PERCENT: 0.75 | PAYMENT DUE: 697696.67 | |

A CRN _ F ST APPR AMT OVRD AMT PAID AMT BEG DATE END DATE _ 142810005000 I PR 955262.23 0.00 0.00 10/01/14 11/28/14

B. CRA case creation is requested which requires the RI unit to apply a price override amount of $650,000 to CRN 142810005001 so the regular Reinsurance case total value minimum requirement of $650,000 is met:

| TR: RI120 ACT C | AHCCCS - REINSURANCE | USER-ID: L88 | 10/10/14 |
| CASE NUMBER: R330000004 | PA CASE NO: | |
| CASE TYPE: RAC REGULAR ACUTE REINSURANCE (CYE 07+) | AHCCCS ID: | |
| RECIPIENT: TEST, JACKSON | HEALTH PLAN: | |
| HEALTH PLAN: | DEDUCTIBLE: 25000.00 | |
| HEALTH PLAN: | TTL PAYABLE: 468750.00 | |
| HEALTH PLAN: | TTL RCVRY: 0.00 | |
| HEALTH PLAN: | TTL PREM TX: 0.00 | |
| ALLOWED AMT: 650000.00 | LIABILITY: 625000.00 | |
| CASE TOTAL: 650000.00 | TOTAL PAID: 0.00 | |
| RI PERCENT: 0.75 | PAYMENT DUE: 468750.00 | |

A CRN _ F ST APPR AMT OVRD AMT PAID AMT BEG DATE END DATE _ 1428100005000 I PR 955262.23 650000.00 0.00 10/01/14 11/28/14

(A)CT: (S) ELECT (E) DIT E(X) CLUDE (P) ERM EXCLUDE (T) RANSFER (D) ENY (V)IEW PRICE
PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=105 6=116 7=UP 8=DWN 9=CNF 10=TOP 11=BOT 12=ESC
C. Catastrophic CRA case created with 305,262.23 carried over from CRN 142810005001 which will remain associated to the RAC case:

1092 CASE SUCCESSFULLY ADDED  
TR: RI105 ACT: A          AHCCCS - REINSURANCE USER-ID: L88 10/10/14  
NTR: _____  RI CASE MAINTENANCE 13:35:57  
CASE NUMBER: R330000005 PA CASE #:  
AHCCCS ID:  RECIPIENT: TEST, JACKSON  
HEALTH PLAN:  PLAN NAME:  
CASE TYPE: CRA CASE DESC: CATASTROPHIC REGULAR ACUTE $650,000  
CTRT YEAR: 33 FFS (Y/N): N  
CASE STA:  A CREATED BY: L88  
ON: 10/10/2014 MM REVIEW DATE:  
BEGIN DATE: 10/01/2014 THRU DATE: 09/30/2015  
DEDUCTIBLE: .00 RI PMT PCT: 1.00  
650K PLUS $$ 305262.23 TTL ALLOWED: 0.00  
TTL PAID: 0.00 TTL PREM TAX:  
CVG PKG(S):  
PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRV 6=NXT 7=EXCP 9=CNF 10=PMT 11=CMT 12=ESC

D. The carried over amount from the RAC case will now pay at 100% on the Catastrophic case:

TR: RI120 ACT I          AHCCCS - REINSURANCE USER-ID: L88 10/10/14  
NTR: _____  RI CASE SUMMARY 13:43:11  
CASE NUMBER: R330000005 PA CASE #:  
CASE TYPE: CRA CATASTROPHIC REGULAR ACUTE $650,000  
RECIPIENT: TEST, JACKSON  
HEALTH PLAN:  
AHCCCS ID:  
DEDUCTIBLE: 0.00 TTL PAYABLE: 305262.23  
650K PLUS $$ 305262.23 TTL RCVRY: 0.00 TTL PREM TX: 0.00  
ALLOWED AMT: 0.00 LIABILITY: 305262.23 TOTAL PAID: 0.00  
CASE TOTAL: 305262.23 RI PERCENT: 1.00 PAYMENT DUE: 305262.23  
A CRN F ST APPR AMT OVRD AMT PAID AMT BEG DATE END DATE

(A)CT: (S)ELECT (E)DIT (E/X)CLUDE (P)ERM EXCLUDE (T)RANSFER (D)ENY (V)IEW PRICE  
PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=105 6=116 7=UP 8=DWN 10=TOP 11=BOT 12=ESC

3
Non-Covered/Denied/Disallowed Charges on Transplant

Transplant Stage Invoice Cover Sheet

Mail or deliver to:
AHCCCS / DHCM / Reinsurance Unit
701 East Jefferson Street
Mail Drop 6600
Phoenix, Arizona 85034
Fax 602-417-4725

Date: 10/01/2014

Contractor Name (Health Plan or Program Contractor)
AHCCCS ID # for Contractor and Facility
Submitted By
Contact Phone Number
E-mail address
Recipient Name
Recipient AHCCCS ID #
AHCCCS Transplant Case Number
Stage Description
Stage Number & Stage Name
Stage Dates of Service
Total Billed Charges for Stage
Contractor Paid Amount

Box A1
Listing of Non-payable charges due to OPFS CEN(s) listed in numerical order by form type
O - 1195902 XXXXX $2459.48
O - 1132200 XXXXX $609.24
O - 1132100 XXXXX $527.00

Total $ 3565.72

Box A2
Listing of Denied Services CEN(s) listed in numerical order by form type
A - 1309507097 XXXXX $81.00

Total $ 81.00

Reinsurance Action
Request Form Attached
Yes ☐ or No ☒

Submission must include the following:
Facility Invoice, Proof of Payment, Facility Claims (totaled by form type), Letter of Agreement
(if place of service is a non-contracted facility)

Box B minus Box A2 must equal Box C

Box B TBC from Attached Claims
Attached Form I Total $ 0.00
Attached Form O Total $ 18,329.80
Attached Form A Total $ 2,336.00
Attached Form C Total $ 0.00

Box C TBC from PAMIS Screen
RI115 Form I Total $ 0.00
RI115 Form O Total $ 18,329.80
RI115 Form A Total $ 2,255.00
RI115 Form C Total $ 0.00

Rev 06/14
Charges which are disallowed due to invalid Outpatient Fee Schedule code sets are to be listed in Box A1. These charges are counted as part of total billed charges and are encountered in the PMMIS as non-covered lines.

Denied Services are to be listed in Box A2. Denied Services are defined per AHCCCS Encounter Manual as encounters for Contractor adjudicated claims that have been denied or non-covered in full. These charges are encountered as denied/non-covered charges per AHCCCS Encounter manual.

The Total Billed Charges (TBC) of the claims submitted with the Transplant Stage Invoice Coversheet are listed by form type in Box B.

The Total Billed Charges (TBC) from the RI115 screen in PMMIS are listed by form type in Box C.

Box B minus A2 will equal Box C.

Box A2 are disallowed charges and are not subtracted from the total billed charges.

**Condition code 61**

Based on comments from Contractors at the workshop on October 1st all transplant facilities were informed to use the condition code 61 when the claim for the days 11+/61+ is to be paid as an outlier.