Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers

4.3.1 Introduction

In Arizona, the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI) were developed as behavioral health "carve-outs," a model in which eligible persons receive general medical services through health plans and covered behavioral health services through behavioral health managed care organizations, also known as Tribal and Regional Behavioral Health Authorities (T/RBHAs). Because of this separation in responsibilities, communication and coordination between behavioral health providers, the Arizona Health Care Cost Containment System (AHCCCS) Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of persons receiving services from both systems.

Some behavioral health recipients are Medicaid (Title XIX/XXI) and Medicare (Title XVIII) eligible and are referred to as "dual eligible" persons. Medicare covers limited inpatient behavioral health services, outpatient behavioral health services and prescription medication coverage. Medicare covered behavioral health services are provided on either a fee-for-service basis or a managed care basis (through Medicare Advantage Plans). The term Medicare Provider refers to both the fee-for-service Medicare providers and the Medicare Advantage Plans. Coordination of care must also occur with Medicare providers to achieve positive health outcomes for Medicare eligible behavioral health recipients.

Holistic treatment requires integration of physical health with behavioral health to improve the overall health of an individual. Behavioral health recipients may be receiving care from multiple health care entities. Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a person. For this reason, communication and coordination of care between behavioral health providers, PCPs and Medicare providers must occur on a regular basis to ensure safety and positive

clinical outcomes for persons receiving care. For T/RBHA enrolled persons not eligible for Title XIX or Title XXI coverage, coordination and communication should occur with any known health care provider(s).

4.3.2 References

The following citations can serve as additional resources for this content area:

42 CFR 400.202
42 CFR 409.62
42 CFR 422.2
42 CFR 422.4
42 CFR 422.106
42 CFR 422.114
42 CFR 423.4
42 CFR 423.34
42 CFR 423.100
42 CFR 423.104
42 CFR 423.272
42 CFR 423.505
42 CFR 438.208
A.R.S. § 32-1901
A.R.S. § 36-545.04
9 A.A.C.20
9 A.A.C.21
A.A.C. R9-22-210.01
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/Tribal IGAs
CMS Medicare Benefit Policy Manual
AHCCCS Behavioral Health Services Guide
AHCCCS Medical Policy Manual
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.3, Referral and Intake Process
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.17, Transition of Persons
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have Serious Mental Illness (SMI)
Section 3.22, Out-of-State Placements for Children and Young Adults
Section 4.1, Disclosure of Behavioral Health Information
Section 6.1, Submitting Tribal Fee For Service Claims to AHCCCS
Section 6.2, Submitting Claims and Encounters to the RBHA
Section 7.5, Enrollment, Disenrollment and Other Data Submission
Section 9.1 Training Requirements
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Practice Improvement Protocol, Pervasive Developmental Disorders and Developmental Disabilities

ADHS/DBHS Policy Clarification Memorandum: Coordination of Care Between AHCCCS Health Plan PCPs and Other PCPs in the Behavioral Health System
ADHS/DBHS Policy Clarification Memorandum: Coordination of Care with AHCCCS Health Plans and Primary Care Physicians

4.3.3 Scope

To whom does this apply?

All Title XIX and Title XXI eligible persons and all other T/RBHA enrolled persons receiving services from other health care providers.

4.3.4 Did you know…?

As of October 1, 2010, AHCCCS began automatically enrolling all Acute Care eligible members with a behavioral health benefit into a T/RBHA. Members are assigned based on the zip code in which they reside.

Each quarter, ADHS/DBHS is partnering with the T/RBHAs to introduce particular medical topics which impact individuals receiving behavioral health services.

Each AHCCCS Health Plan has a "Behavioral Health Coordinator." The Behavioral Health Coordinator can serve as a contact person and resource for behavioral health providers when problems arise concerning a person's medical care or any other health plan related issue. A Behavioral Health Coordinator may act on behalf of the PCP. See PM Attachment 4.3.1 for contact information for each AHCCCS Health Plan and Behavioral Health Coordinator.

T/RBHAs are required to identify at least one single point of contact within the T/RBHA to be named the Acute Health Plan and Provider Coordinator. This contact person's main role is to respond to coordination of care inquiries from AHCCCS Health Plans, primary care providers (PCPs) and other involved clinicians to facilitate clinical coordination of care. When coordinating care with the person's PCP, Medicare provider or other health care provider, information must be disclosed in accordance with Section 4.1, Disclosure of Behavioral Health Information.

In accordance with R9-22-210.01, hospitals, emergency room providers, or fiscal agents are required to notify T/RBHAs or their subcontracted providers no later than the 11th day from presentation of Title XIX/XXI eligible members for emergency inpatient behavioral health services.

AHCCCS eligible individuals who are automatically assigned to a T/RBHA may or may not access behavioral health services. When an AHCCCS eligible individual does receive behavioral health services through a T/RBHA, the T/RBHA must track an individual's "episode of care" in accordance with Section 7.5, Enrollment, Disenrollment and Other Data Submission.

As of January 1, 2006, AHCCCS no longer provides prescription drug coverage for dual eligible persons, except for certain excluded Medicare Part D drugs, in accordance with the Medicare Prescription Drug Modernization and Improvement Act of 2003. Medicare eligible persons must enroll in a Medicare Part D plan to receive prescription drug coverage through Medicare. Some

Medicare Advantage plans contract with the T/RBHAs to provide the Part A, Part B and/or Part D benefit.

4.35 Definitions

Acute Health Plan and Provider Coordinator

Behavioral Health Medical Practitioner

Medicare Advantage Prescription Drug Plan (MA-PD)

Prescription Drug Plan (PDP)

Prior Period Coverage

4.3.6 Objectives

To ensure that timely communication and coordination of care occurs between the T/RBHAs, subcontracted behavioral health providers, AHCCCS Health Plan PCPs, Medicare Providers or other health care provider(s), regarding a T/RBHA enrolled person's behavioral health and general medical care and treatment.

4.3.7 Procedures

4.3.7-A. Coordinating care with AHCCCS Health Plans

The following procedures will assist behavioral health providers in coordinating care with AHCCCS Health Plans:
If the identity of the person's primary care provider (PCP) is unknown, a behavioral health provider must contact the Acute Health Plan and Provider Coordinator(s) for the T/RBHA or the Behavioral Health Coordinator of the person's designated health plan to determine the name of the person's assigned PCP. See the AHCCCS Contracted Health Plans, PM Attachment 4.3.1 for contact information for the Behavioral Health Coordinators for each AHCCCS Health Plan.

T/RBHA enrolled persons who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. T/RBHA enrolled persons should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.

Behavioral health providers should request medical information from the person's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. ADHS/DBHS has developed a sample request form that may be utilized for this purpose (see PM Form 4.3.2, Request for Information from PCP or Medicare Provider). WMABHS utilizes the IHS Release of Information form that is submitted to Whiteriver IHS Medical Records. If the PCP does not respond to the request, contact the health plan's Behavioral Health Coordinator for assistance.

Behavioral health providers must address and attempt to resolve coordination of care issues with AHCCCS Health Plans and PCPs at the lowest possible level. If problems persist, contact the assigned case manager or Medical Records Specialist at the T/RBHA.

4.3.7-B. The T/RBHA Acute Health Plan and Provider Coordinator

T/RBHAs are required to designate an Acute Health Plan and Provider Coordinator who must gather, review and communicate clinical information requested by PCPs, Acute Care Plan Behavioral Health Coordinators and other treating professionals or involved stakeholders (see PM Attachment 4.3.2, T/RBHA Acute Health Plan and Provider Coordinator Contact Information).

The T/RBHA must have a designated and published phone number for the Acute Health Plan and Provider Coordinator or a clearly recognized prompt on an existing phone number that facilitates prompt access to the Acute Health Plan and Provider Coordinator and that must be staffed during business hours.

T/RBHAs must ensure that T/RBHA Acute Health Plan and Provider Coordinator's receive training which includes, at a minimum, the following elements:

- Provider inquiry processing and tracking (including resolution timeframes);
- T/RBHA procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources (see PM 6.2, Submitting Claims and Encounters to the RBHA);
- Claim dispute and appeal procedures (PM 5.6,Provider Claims Disputes); and
- Identifying and referring quality of care issues.

WMABHS Medical Records Manager acts as the Acute Health Plan Coordinator for acute care episodes of care. Please call (928) 338-4811 Ext. 2223 or patty@wmabhs.org.

The WMABHS Provider Network Coordinator develops contracts and provides orientation for providers interested in contracting with WMABHS. WMABHS is a Fee-For–Service Provider, and an IHS '638' contracted provider; this means all providers contracting with WMABHS contract as a Fee-For-Service Provider for American Indian Health Programs and must be contracted with AHCCCS as such, this means providers bill directly to AHCCCS the TRBHA has no funds to pay for any services other than room and board, for specific clients. Please contact the WMABHS Provider Network Coordinator at (928) 338-4811 Ext.2258 or bjcosay@wmabhs.org for additional information.

WMABHS contracted providers may utilize the AHCCCS Technical Assistance for American Indian Health Programs by contacting Fee-For-Service Director; at 602-417-4562 or Albert.Escobedo@azahcccs.gov for assistance with appropriate billing practices.

All Quality of Care issues should be addressed to the WMABHS QM Department/Clinical Director; QM Administrator (928) 338-4811 Ext. 2231 or jnaue@wmabhs.org; Clinical Director (928) 338-4811 Ext. 2228 or dwest@wmabhs.org

All billing is direct to AHCCCS and must be resolved by the Fee-For-Service Director. Grievances are filed directly with ADHS/DBHS as outlined in the WMABHS version of the Provider Manual PM 6.2, Submitting Claims and Encounters which can be found at www.wmabhs.org by clicking on Menu Selection and selecting Handbooks and Manuals, select Provider Manual.

4.3.7-C. Sharing information with PCPs, AHCCCS Acute Health Plans, other treating professionals, and involved stakeholders

To support quality medical management and prevent duplication of services, behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible persons to the assigned PCP, AHCCCS Acute Health Plans, other treating professionals and other involved stakeholders within the following required timeframes:

- "Urgent" – requests for intervention, information, or response within 24 hours.
- "Routine – Requests for intervention, information, or response within 10 days.

For all behavioral health recipients referred by the PCP and have been determined to have a Serious Mental Illness and/or a diagnosis of a chronic medical condition on Axis III, the following information must be provided to the person's assigned PCP:

- The person's diagnosis; and
- The person's current prescribed medications (including strength and dosage).

T/RBHAs and/or subcontracted providers must provide the required information annually, and/or when there is a significant change in the person's diagnosis and/or prescribed medications.

For all Title XIX/XXI enrolled persons, behavioral health providers are required to:

- Notify the assigned PCP of the results of PCP initiated behavioral health referrals;
- Provide a final disposition to the health plan Behavioral Health Coordinator in response to PCP initiated behavioral health referrals, (for more information on the referral process, see Section 3.3, Intake and Referral Process);
- Coordinate the placement of persons in out-of-state treatment settings as described in Section 3.22, Out-of State Placement for Children and Young Adults;
- Notify, consult with or disclose information to the assigned PCP regarding persons with Pervasive Developmental Disorders and Developmental Disabilities, such as the initial assessment and treatment plan and care and consultation between specialists;

- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the behavioral health recipient's medical record; and

- Notify, consult with or disclose other events requiring medical consultation with the person's PCP.

Upon request by the PCP or member, information for any enrolled member must be provided to the PCP consistent with requirements outlined in Section 4.1, Disclosure of Behavioral Health Information.

When contacting or sending any of the above referenced information to the person's PCP, behavioral health providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

ADHS/DBHS has developed a communications form (PM Form 4.3.1) for coordinating care with the AHCCCS Health Plan PCP or Behavioral Health Coordinator. The form includes the required elements for coordination purposes and must be completed in full for coordination of care to be considered to occur. For complex problems, direct provider-to-provider contact is recommended to support written communications.

PM Form 4.3.1 will not have to be used if there is a properly documented progress note. To be considered properly documented the progress note must:

- Include a header that states "Coordination of Care";
- Be legible; and
- Include all of the required elements contained in PM Form 4.3.1.
- The T/RBHA must track/log all the requests received from PCPs, AHCCCS Acute Health Plans, other treating professionals and other involved stakeholders, (see PM Form 4.3.3 T/RBHA Acute Health Plan and Provider Inquiry Monthly Log).
- Completed PM Form 4.3.3, T/RBHA Acute Health Plan and Provider Inquiry Monthly Log, must be submitted to ADHS/ DBHS by the 30th day after the end of the month.

Submission of the Acute Health Plan and Provider Inquiry Logs must be timely. The T/RBHA may be subject to corrective action if not compliant with this requirement.

ADHS/DBHS will communicate items of concern with T/RBHAs, if there are systemic issues evident in the information submitted on the T/RBHA Acute Health Plan and Provider Inquiry Monthly Log. T/RBHAs must resolve any such noted systemic issues.

4.3.7-D. Responsibility for fee-for-service persons

It is the responsibility of the T/RBHA to provide fee-for-service behavioral health services to Title XIX/XXI eligible persons not enrolled with an AHCCCS Health Plan.

The T/RBHA is responsible for providing all inpatient emergency behavioral health services for fee-for-service persons with psychiatric or substance abuse diagnoses.

The T/RBHA is responsible for behavioral health services to Native American Title XIX and Title XXI eligible persons referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

4.3.7-E. Responsibility for persons enrolled in an AHCCCS Health Plan

Services which may have been covered by the AHCCCS Health Plan Contractor for Prior Period Coverage will now be the responsibility of the T/RBHA. This is limited to the behavioral health services only and after the individual has been medically cleared. The Health Plan Contractor is still obligated to provide all necessary medical services.

The following rules apply for other areas of coverage:

Pre-petition Screenings and Court Ordered Evaluations
Payment for pre-petition screenings and court ordered evaluations is the responsibility of the county.

Emergency Behavioral Health Services
When a Title XIX or Title XXI eligible person presents in an emergency room setting, the person's AHCCCS Health Plan is responsible for all emergency medical services including triage, physician assessment, and diagnostic tests.

The T/RBHA, or when applicable, its designated behavioral health provider, is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all Title XIX and Title XXI persons enrolled with a T/RBHA.

The T/RBHA is responsible for providing all non-inpatient emergency behavioral health services to Title XIX and Title XXI eligible persons. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling. [1]

The T/RBHA is responsible for providing all inpatient emergency behavioral health services to persons with psychiatric or substance abuse diagnoses for all Title XIX and Title XXI eligible persons.

Emergency transportation of a Title XIX or Title XXI eligible person to the emergency room (ER) when the person has been directed by the T/RBHA or T/RBHA provider to present to this setting in order to resolve a behavioral health crisis is the responsibility of the T/RBHA. The T/RBHA or subcontracted provider directing the person to present to the ER must notify the emergency transportation provider of the T/RBHAs fiscal responsibility for the service.

Emergency transportation of a Title XIX or Title XXI eligible person required to manage an acute medical condition, which includes transportation to the same or higher level of care for

[1] Note: in inpatient settings, these services would be included in the per diem rate.

immediate medically necessary treatment, is the responsibility of the person's AHCCCS Health Plan.

For information on emergency services for Non-Title XIX/XXI persons see Section 3.25, Crisis Intervention Services

Non-emergency Behavioral Health Services
For Title XIX and Title XXI eligible persons, the T/RBHA is responsible for the provision of all non-emergency behavioral health services.

If a Title XIX or Title XXI eligible person is assessed as needing inpatient psychiatric services by the T/RBHA or subcontracted provider prior to admission to an inpatient psychiatric setting, the T/RBHA is responsible for authorization and payment for the full inpatient stay, as per PM Section 3.14, Securing Services and Prior Authorization.

When a medical team or health plan requests a behavioral health or psychiatric evaluation prior to the implementation of a surgery, medical procedure or medical therapy to determine if there are any behavioral health contraindications, the T/RBHA is responsible for the provision of this service. Surgeries, procedures or therapies can include gastric bypass, interferon therapy or other procedures for which behavioral health support for a patient is indicated.

Non-emergency Transportation
Transportation of a Title XIX or Title XXI eligible person to an initial behavioral health intake appointment is the responsibility of the T/RBHA.

Medical Treatment for Persons in Behavioral Health Treatment Facilities
When a Title XIX or Title XXI eligible person is in a Level II or Level III residential treatment center and requires medical treatment, the AHCCCS Health Plan is responsible for the provision of covered medical services.

If a Title XIX or Title XXI eligible person is in a Level I psychiatric facility and requires medical treatment, those services are included in the per diem rate for the treatment facility. If the person requires inpatient medical services that are not available at the Level I psychiatric facility, the person must be discharged from the psychiatric facility and admitted to a medical facility. The AHCCCS Health Plan is responsible for medically necessary services received at the medical facility, even if the person is enrolled with a T/RBHA.

4.3.7-F. PCPs prescribing psychotropic medications

Within their scope of practice and comfort level, an AHCCCS Health Plan PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that AHCCCS Health Plan PCPs can treat are:

- Attention-Deficit/Hyperactivity Disorder;
- Uncomplicated depressive disorders; and
- Anxiety disorders.

The "Agreed Conditions"
Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for persons under the care of both a health plan PCP and behavioral health provider simultaneously. The following conditions apply:

- Title XIX and Title XXI eligible persons must not receive medications for psychiatric disorders from the health plan PCP and behavioral health provider simultaneously. If a person is identified to be simultaneously receiving medications from the health plan PCP and behavioral health provider, the behavioral health provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the person's behavioral health condition.
- Medications prescribed by providers within the T/RBHA behavioral health system must be filled by T/RBHA contracted pharmacies under the T/RBHA pharmacy benefit (see exceptions to this requirement for dual eligible persons in subsection 4.3.7-F, Coordination of care with Medicare providers). This is particularly important when the pharmacy filling the prescription is part of the contracted pharmacy network for both the prescribing T/RBHA and the person's AHCCCS Health Plan. The T/RBHA and contracted providers must take active steps to ensure that prescriptions written by providers within the T/RBHA system are not charged to the person's AHCCCS Health Plan.

Transitions of persons with ADHD, depression, and/or anxiety to the care of their Primary Care Physician
Members who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), depression, and/or anxiety and who are stable on their medications may transition back to the care of their PCP for the management of these diagnoses, as long as the member, their guardian or parent and the PCP agree to this treatment transition. The T/RBHA is required to facilitate this process and to ensure that the following steps are taken:

- The T/RBHA must contact the member's PCP to discuss the member's current medication regime and to confirm that the PCP is willing and able to provide treatment for the member's ADHD, depression, and/or anxiety.
- If the PCP agrees to transition treatment for the member's diagnosis of ADHD, depression and/or anxiety, the T/RBHA must provide the PCP with a transition packet that includes (at a minimum):
- A written statement indicating that the member is stable on a medication regime;
- A medication sheet or list of medications currently prescribed by the T/RBHA Behavioral Health Medical Practitioner (BHMP);
- A psychiatric evaluation;
- Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member; and
- A discharge summary outlining the member's care and any adverse responses the member has had to treatment or medication.

- A copy of the packet must be sent to the member's AHCCCS Health Plan Behavioral Health Coordinator as well as to the member's PCP.

- The T/RBHA will ensure that the member's transition to the PCP is seamless, and that the member does not go without medications during this transition period.

- Each month, the T/RBHA will complete Form 4.3.4 Member Transition from T/RBHA to PCP Tracking Log and submit it to ADHS/DBHS in order to monitor the transition process.

WMABHS is a TRBHA, IHS '638' contracted facility so all medication and pharmacy services are provided by the Whiteriver IHS Hospital and/or the Phoenix Indian Medical Center. The WMABHS Intake Specialist will ensure all clients sign a release of Information from IHS to ABHS for the Medical Face Sheet and Medication Listing, to be filed in the client chart, and will update the request annually in January. The Out of Home Case Manager will request an original medication listing, and updates with the monthly or quarterly progress reports from the Level II, III or IV Provider for clients placed off reservation. Providers serving WMABHS enrolled clients residing in Level II, III, or IV residential facilities off reservation may develop a Single Case Agreement with WMABHS. The provider's therapist must coordinate with the WMABHS assigned therapist to determine that a single case agreement is required. The WMABHS Therapist will coordinate with the WMABHS Network Provider Coordinator to establish the Single Case Agreement. The provider will directly bill AHCCCS for these services as a American Indian Health Care Fee-For-Service Provider.

General Psychiatric Consultations

Behavioral health medical practitioners must be available to AHCCCS Health Plan PCPs to answer diagnostic and treatment questions of a general nature.

General psychiatric consultations are not person specific and are usually conducted over the telephone between the PCP and the behavioral health medical practitioner.

One-Time Face-to-Face Psychiatric Evaluations

Behavioral health providers must be available to conduct a face-to-face evaluation with a Title XIX/XXI eligible person upon his/her PCPs request in accordance with Section 3.2, Appointment Standards and Timeliness of Service.

A one-time face-to-face evaluation is used to answer PCPs specific questions and provide clarification and evaluation regarding a person's diagnosis, recommendations for treatment, need for behavioral health care, and/or ongoing behavioral health care or medication management provided by the PCP.

The PCP must have seen the person prior to requesting a one-time face-to-face psychiatric evaluation with the behavioral health provider.

AHCCCS Health Plan PCPs must be provided current information about how to access T/RBHA psychiatric consultation services. The Whiteriver IHS psychiatrist provides psychiatric services

for WMABHS clients residing on the reservation. Providers serving WMABHS enrolled clients residing in Level II, III, or IV residential facilities off reservation may utilize the Phoenix Indian Medical Center psychiatrist or may need to develop a Single Case Agreement.
The T/RBHA is obligated to offer general consultations and one-time face-to-face psychiatric evaluations and must provide direct and timely access to behavioral health medical practitioners (physicians, nurse practitioners and physician assistants) or other behavioral health practitioners if requested by the PCP.

4.3.7-G. Coordination of care with Medicare providers

Medicare Advantage plans
Medicare health plans, also known as Medicare Advantage (MA) plans, are managed care entities that have a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries. MA plans provide the full array of Medicare benefits, including Medicare Part A, hospital insurance, and Medicare Part B, medical insurance. As of January 1, 2006, MA plans also included Medicare Part D, prescription drug coverage.

Many of the AHCCCS Contracted Health Plans are MA plans (see PM Attachment 4.3.1). These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible persons and are referred to as MA-PD SNPs (Medicare Advantage-Prescription Drug/Special Needs Plans).

Some MA plans contract with the T/RBHA to provide some or all of the Medicare covered behavioral health services. In such cases, coordination of care should be simplified as the T/RBHA is providing Title XIX and state funded behavioral health services, as well as Medicare behavioral health services. Coordination with MA plans must be attempted by the T/RBHA and/or behavioral health provider when the Medicare behavioral health services are provided by the MA plan. ADHS/DBHS has developed sample forms for use when requesting or sharing information for purposes of coordinating care with Medicare providers (see PM Form 4.3.1, Communication Document, and PM Form 4.3.2, Request for Information from PCP or Medicare Plan/Provider).

WMABHS enrolled clients eligible for Medicare utilize the Medicare Fee-For-Service Program utilizing IHS providers.

Medicare Fee-for-Service Program
Instead of enrolling in a Medicare Advantage plan, Medicare eligible behavioral health recipients may elect to receive all Medicare services (Parts A, B and/or D) through any provider authorized to deliver Medicare services. Therefore, behavioral health recipients in the Medicare Fee-for-Service program may receive services from Medicare registered providers in the T/RBHA provider network.

Inpatient Psychiatric Services
Medicare has a lifetime benefit maximum for inpatient psychiatric services. T/RBHA cost sharing responsibilities and billing for inpatient psychiatric services must be in accordance with Section 3.5, Third Party Liability and Coordination of Benefits, and Section 6.1, Submitting Tribal

Fee for Service Claims to AHCCCS and Section 6.2, Submitting Claims and Encounters to the RBHA.

Inpatient psychiatric service providers providing services to WMABHS enrolled clients submit claims directly to AHCCCS as an American Indian Health Fee-For-Service provider.

Outpatient Behavioral Health Services

Medicare provides some outpatient behavioral health services that are also ADHS/DBHS covered behavioral health services. T/RBHA cost sharing responsibilities and billing for outpatient behavioral health services must be in accordance with Section 3.5, Third Party Liability and Coordination of Benefits, Section 6.1, Submitting Tribal Fee For Service Claims to AHCCCS and Section 6.2, Submitting Claims and Encounters to the RBHAs.

Outpatient BH service providers providing services to WMABHS enrolled clients submit claims directly to AHCCCS as an American Indian Health Fee-For-Service provider.

Prescription Medication Services

Medicare eligible behavioral health recipients must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) to receive the Part D benefit. PDPs only provide the Part D benefit and any Medicare registered provider may prescribe medications to behavioral health recipients enrolled in PDPs. Some MA-PDs may contract with the T/RBHA or T/RBHA providers to provide the Part D benefit to Medicare eligible behavioral health recipients.

WMABHS is a TRBHA, IHS '638' contracted facility so all medication and pharmacy services are provided by the Whiteriver IHS Hospital and/or the Phoenix Indian Medical Center. Providers serving WMABHS enrolled clients residing in Level II, III, or IV residential facilities off reservation may develop a Single Case Agreement with WMABHS and submit claims directly to AHCCCS as an American Indian Health Fee-For-Service provider.

While PDPs and MA-PDs are responsible for ensuring prescription drug coverage to behavioral health recipients enrolled in their plans, there are some prescription medications that are not included on plan formularies (non-covered) or are excluded Part D drugs. The T/RBHA is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on the T/RBHA formulary, in addition to Part D cost sharing, in accordance with Section 3.5, Third Party Liability and Coordination of Benefits, and Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI).