

Arizona Department of Health Services
Division of Behavioral Health Services
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Section 4.3 **Coordination of Care with AHCCCS Health Plans,
Primary Care Providers and Medicare Providers**

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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 Regional Behavioral Health Authorities and Tribal Behavioral Health Authorities (T/RBHAs). Because of this separation in responsibilities, communication and coordination between behavioral health providers, 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.

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 medical care provider.

4.3.2 References

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

[42 CFR 400.202](#)

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[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](#)

[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](#)

[ADHS/DBHS Practice Improvement Protocol, Pervasive Developmental Disorders and Developmental Disabilities](#)

[Section 4.1, Disclosure of Behavioral Health Information](#)

[Section 3.3, Referral Process](#)

[Section 3.5, Third Party Liability and Coordination of Benefits](#)

[Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding](#)

[Section 3.22, Out-of-State Placements for Children and Young Adults](#)

[Section 3.2, Appointment Standards and Timeliness of Service](#)

[Section 6.1, Submitting Claims and Encounters](#)

[Section 9.1 Training Requirements](#)

[ADHS/DBHS Covered Behavioral Health Services Guide](#)

[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 with other health care provider(s).

4.3.4 Did you know...?

- 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

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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.

- 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](#).
- As per [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.
- The T/RBHA must not contact the AHCCCS Health Plan to request services authorized by the T/RBHA after the date of enrollment.
- 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.

4.3.5 Definitions

[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 primary care providers (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. Suggestions and guidance for 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 can contact the member services department 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 each AHCCCS Health Plan.

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- 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 may 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](#) and [PM Form 4.3.1 Communication Document](#)). 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 Health Plan Liaison at the T/RBHA.

4.3.7-B. Sharing information with the PCPs and AHCCCS Health Plans

Behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible persons to the assigned PCP as needed to support quality medical management and prevent duplication of services. At a minimum, for all behavioral health recipients referred by the PCP or who have been determined to have a serious mental illness, 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 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 referrals. For more information on the referral process, see [Section 3.3, 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;

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- Provide a copy of to the PCP of an 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, 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 need to provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

ADHS/DBHS has developed a sample communications form ([PM Form 4.3.1](#)) for coordinating care with the AHCCCS Health Plan PCP or Behavioral Health Coordinator. The sample form includes the required elements for coordination purposes. Any other forms developed for use in communicating with the AHCCCS Health Plan PCP/Behavioral Health Coordinator must be submitted through the T/RBHA for approval by the ADHS/DBHS Medical Director's Office. For complex problems, direct provider-to-provider contact is recommended to support written communications.

4.3.7-C. 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-D. Who is responsible, the AHCCCS Health Plan or the T/RBHA?

Depending on certain factors, an AHCCCS Health Plan or the T/RBHA may be responsible for responding to and/or providing care to Title XIX and Title XXI eligible persons. The following rules apply:

Prior Period Coverage

When a person is determined Title XIX eligible, the AHCCCS Health Plan is responsible for the payment of covered behavioral health services during prior period coverage, regardless of the person's enrollment status with a T/RBHA.

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Pre-petition Screenings and Court Ordered Evaluations

Pre-petition screenings and court ordered evaluations are exceptions to services that the AHCCCS Health Plan is responsible for during prior period coverage. 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. Emergency services do not include psychiatric or psychological consultations for T/RBHA enrolled persons.

The T/RBHA, or when applicable, its designated behavioral health provider, is responsible for psychiatric and/or psychological consultations in emergency room settings provided to Title XIX and Title XXI persons enrolled with a T/RBHA. If a Title XIX or Title XXI person is not enrolled with the T/RBHA, the AHCCCS Health Plan is responsible.

The T/RBHA is responsible for providing all non-inpatient emergency behavioral health services to Title XIX/XXI eligible persons. Examples of these non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling. (Note: in inpatient settings, these services would be included in the per diem rate.)

For Title XIX and Title XXI eligible persons, The T/RBHA is responsible for providing all inpatient emergency behavioral health services to persons with psychiatric or substance abuse diagnoses from one of the following time periods, whichever comes first:

- The date on which the person becomes enrolled with a T/RBHA; or
- The seventy-third hour after admission for inpatient emergency behavioral health services.

The AHCCCS Health Plan is responsible for providing inpatient emergency behavioral health services to persons with psychiatric or substance abuse diagnoses who are enrolled with the AHCCCS Health Plan and are not enrolled with a T/RBHA for the first 72 hours after admission.

Emergency transportation of a Title XIX or Title XXI eligible person to the emergency room 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 its 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 immediate medically necessary treatment is the responsibility of the person's AHCCCS Health Plan.

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Non-emergency Behavioral Health Services

The T/RBHA must enroll a Title XIX/XXI eligible person as of the first date of service. For Title XIX and Title XXI eligible persons, the T/RBHA is responsible for the provision of all non-emergency behavioral health services, whether or not there has been a determination of behavioral health recipient status. The T/RBHAs is not responsible for the payment of medically necessary behavioral health services for Title XIX/Title XXI AHCCCS eligible members during prior period coverage that results from retroactive eligibility.

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 AHCCCS Health Plan is responsible for the provision of this service, if the Title XIX or XXI eligible person is not enrolled in a T/RBHA. If the person is enrolled with a T/RBHA, the T/RBHA is responsible. 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/XXI eligible person to an initial behavioral health intake appointment is the responsibility of the AHCCCS Health Plan. Transportation to all ongoing behavioral health services 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-E. 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.

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The “Agreed Conditions”

Certain requirements and guiding principles have been established under the *Psychotropic Medication Initiative*. 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.

Title XIX and Title XXI eligible persons who are being treated by the behavioral health provider for the above listed disorders and are clinically stable may be referred to the PCP for ongoing care following:

- Consultation with the person’s PCP;
- Acceptance by the person’s PCP and AHCCCS Health Plan; and
- Approval by the person.

If a Title XIX or Title XXI eligible person is receiving medication management services through the PCP, other behavioral health services such as counseling can be provided by the behavioral health provider with the expectation that close coordination of care and communication between the PCP and behavioral health provider occurs.

Psychiatric Consultations

There are two (2) types of psychiatric consultations available under the *Psychotropic Medication Initiative*:

- General Psychiatric Consultations; and
- One-Time Face-to-Face Psychiatric Consultations.

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.

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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 consultation 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 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-F. 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.

Five 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 (refer to [PM Form 4.3.1, Communication Document](#), and [PM Form 4.3.2, Request for Information from PCP or Medicare Plan/Provider](#)).

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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 Claims and Encounters](#). Medicare A and B does require prior authorization from Magellan Health Services for initial placement and concurrent reviews to authorize continued stay. The provider needs to bill Medicare then receive an EOB or denial letter. Attach the EOB and denial letter and submit claim to Magellan Health Services. Medicare payment for TXIX/TXXI Magellan coordinates benefits. Medicare denial may be a possible payment of claim. Magellan Health Services does not coordinate benefits for non TXIX/TXXI individuals with Medicare.

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](#), and [Section 6.1, Submitting Claims and Encounters](#). Magellan Health Services does not require prior authorization for out patient services (refer to [Section 3.14 Securing Services and Prior Authorization](#)). Medicare A and B do not require prior authorization from Magellan Health Services. The provider needs to bill Medicare then receive an EOB or denial letter. Attach the EOB and denial letter and submit claim to Magellan Health Services. Medicare payment for TXIX/TXXI Magellan Health Services coordinates benefits. Medicare denial may be a possible payment of claim. Magellan Health Services does not coordinate benefits for non TXIX/TXXI individuals with Medicare.

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. Refer to section [3.21.7-D Medicare Part D Prescription Drug Coverage](#)

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 Prioritization for Non-Title XIX/XXI Funding](#).

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