

**Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL
*Magellan Health Services of Arizona Edition***

Section 3.5 Third Party Liability and Coordination of Benefits

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3.5.1 Introduction

Third party liability refers to situations in which persons enrolled in the public behavioral health system also have behavioral health service coverage through another health insurance plan, or “third party”. The third party can be liable or responsible for covering some or all the behavioral health services a person receives, including medications. Behavioral health providers are responsible for determining and verifying if a person has third party health insurance before using other sources of payment such as Medicaid (Title XIX), KidsCare (Title XXI) or State appropriated behavioral health funds.

There are two methods used in the coordination of benefits; cost avoidance and post-payment recovery:

- Cost avoidance-Behavioral health providers must cost avoid all claims or services that are subject to third-party payment and may deny a service to a person if it is known that a third party (i.e., other insurer) will provide the service. RBHAs may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to the RBHA. In emergencies, behavioral health providers must provide the necessary services and then coordinate payment with the third party payer.
- Post-payment recovery is necessary in cases where a behavioral health provider was not aware of third party coverage at the time services were rendered or paid for, or was unable to cost avoid.

The intent of this section is to describe the requirements for behavioral health providers Provider Network Organizations (PNOs) to:

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- Determine if a person has third party health insurance coverage before using Federal or State funds;
- Coordinate services and assign benefit coverage to third party payers when information regarding the existence of third party coverage is available; and
- Submit billing information that includes documentation that third party payers were assigned coverage for any covered behavioral health services that were rendered to the enrolled person.

3.5.2 References

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

[42 CFR Part 400](#)

[42 CFR Part 403](#)

[42 CFR Part 411](#)

[42 CFR Part 417](#)

[42 CFR Part 422](#)

[42 CFR Part 423](#)

[A.R.S. § 36-2903 \(F\)](#)

[A.R.S. § 36-3408](#)

[A.R.S. § 36-3409](#)

[A.A.C. R9-21-202\(A\)\(8\)](#)

[A.A.C. R9-22-1001](#)

[A.A.C. R9-22-1002](#)

[A.A.C. R9-22-1003](#)

[A.A.C. R9-22-1005](#)

[A.A.C. R9-22-1009](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contracts](#)

[ADHS/TRBHA Intergovernmental Agreements \(IGAs\)](#)

[AHCCCS Contractor Operations Manual](#)

[AHCCCS Billing Manual for IHS/Tribal Providers](#)

[AHCCCS Fee-for-Service \(FFS\) Provider Manual](#)

[ADHS/DBHS Program Support Procedures Manual](#)

[Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program](#)

[Section 3.3, Referral and Intake](#)

[Section 3.4, Co-payments](#)

[Section 3.9, Assessment and Service Planning](#)

[Section 3.13, Covered Behavioral Health Services](#)

[Section 3.16, Medication Formularies](#)

3.5.3 Scope

To whom does this apply?

All persons seeking services in the public behavioral health system.

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3.5.4 Did you know...?

- If third party information becomes available to the provider at any time for Title XIX or Title XXI eligible persons, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery. Providers report third party information via the following website: <http://www.azahcccs.gov/commercial/ContractorResources/TPL.aspx>. ADHS/DBHS has also established a process for T/RBHAs to report third party information for Title XIX or Title XXI eligible persons daily to ADHS/DBHS on a Third Party Leads submission file. After submitting the file to AHCCCS for verification of the information, T/RBHAs will receive notification of updated information on the TPL files. The T/RBHA is responsible for making third party payer information available to all providers involved with the person receiving behavioral health services.
- Third parties include, but are not limited to, private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, State worker's compensation, first party probate-estate recoveries, long term care insurance and other Federal programs.
- For those Medicare Part A and Part B services that are also covered under Title XIX/XXI, there is no cost sharing obligation if the T/RBHA has a contract with the Medicare provider and the provider's contracted rate includes Medicare cost sharing as specified in the contract.
- As of January 1, 2006, Medicare Part D Prescription Drug coverage became available to all Medicare eligible persons. Medicare is considered third party liability and must be billed prior to use of Title XIX/XXI or state funds.
- Children who qualify for [Adoption Subsidy](#) will be eligible for Title XIX benefits. In addition, their families may also have private insurance. Simultaneous use of the private insurance and Title XIX coverage may occur through the coordination of benefits. Following an intake and assessment, behavioral health providers must determine the services and supports needed. Any necessary services that are not covered through the private insurance, including co-payments and deductibles, may be covered under Title XIX.

3.5.5 Definitions

[Cost avoidance](#) - Avoiding payment of claims when third party payment sources are available.

[Cost sharing](#) – T/RBHA payment on behalf of behavioral health recipients for Medicare and private insurer costs, including premiums, deductibles and coinsurance.

[Dual eligible](#) - Refers to a behavioral health recipient who is eligible for both Title XIX and Medicare services. There are two types of dual eligible behavioral health recipients: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB dual), and Medicare beneficiaries that are not eligible for QMB benefits (Non-QMB dual).

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[Explanation of Benefits](#) - Forms that are sent by payors to both enrollees and providers. Explanation of Benefits (EOBs) provide necessary information about claim payment information and patient responsibility amounts. Patient responsibility amounts are needed for accurate patient balance billing.

[In-network services](#) – Services provided by Tribal and Regional Behavioral Health Authority (T/RBHA) contracted providers.

[Non-QMB dual](#) - A person who is eligible for Title XIX services and has Medicare coverage, but who is not eligible for QMB benefits.

[Out of network services](#) – Services provided by providers that are not contracted with a Tribal or Regional Behavioral Health Authority (T/RBHA).

[QMB dual](#) - A person who is eligible for QMB benefits as well as Title XIX services. QMB duals are entitled to Title XIX services and Medicare Part A and Part B services.

[Remittance Advice](#) - An electronic or paper document submitted to a provider to explain the disposition of a claim.

[Third Party Liability](#) - Payment sources available to pay all or a portion of the cost of services incurred by a person

3.5.6 Objectives

To establish guidelines for behavioral health providers to determine the existence of third party liability and to coordinate benefits for enrolled persons with third party liability.

3.5.7 Procedures

3.5.7-A: How do behavioral health providers know if a person has other health insurance coverage?

Behavioral health providers must inquire about a person's other health insurance coverage during the initial appointment or intake process (See [Section 3.3, Referral and Intake](#)). When behavioral health providers attempt to verify a person's Title XIX or Title XXI eligibility, information regarding the existence of any third party coverage is provided through the automated systems described in [Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program](#). If a person is not eligible for Title XIX or Title XXI benefits, he/she will not have any information to verify through the automated systems. Therefore, the existence of third party payers must be explored with the person during the screening and application process for AHCCCS health insurance.

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3.5.7-B: How do behavioral health providers know what services the other health insurance party will cover?

The third party health insurance coverage may cover all or a portion of the behavioral health services rendered to a person. Behavioral health providers must contact the third party directly to determine what coverage is available to the person. At times, T/RBHAs may incur the cost of co-payments or deductibles for a Title XIX/XXI eligible person or person determined to have a Serious Mental Illness, while the cost of the covered service is reimbursed through the third party payer. Title XIX/XXI funds cannot be used to pay for cost sharing of Medicare Part D Prescription Drug coverage.

3.5.7-C: Billing requirements

Upon determination that a person has third party coverage, a behavioral health provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the person. For specific billing instructions, see the [ADHS/DBHS Program Support Procedures Manual](#) and [AHCCCS Billing Manual for IHS/Tribal Providers](#). The following guidelines must be adhered to by behavioral health providers regarding third party payers:

- ADHS/DBHS and the T/RBHA must be the payers of last resort for Title XIX/XXI and Non-Title XIX/XXI covered services. Payment by another state agency is not considered third party and, in this circumstance, ADHS/DBHS and the T/RBHA are not the payer of last resort.
- Benefits must be coordinated so that costs for services funded by ADHS/DBHS or the T/RBHA are cost avoided or recovered from a third party payer. Providers must bill claims for any covered services to any third party payer when information on that third party payer is available. Documentation that such billing has occurred must accompany the claim when submitted for payment. Such documentation includes a copy of the Remittance Advice or Explanation of Benefits from the third party payer. The only exceptions to this billing requirement are:
 - When a response from the third party payer has not been received within the timeframe established by the T/RBHA for claims submission or, in the absence of a subcontract, within 120 days of submission;
 - When it is determined that the person had relevant third party coverage after services were rendered or reimbursed; or
 - When a behavioral health recipient eligible for both Medicaid and Medicare (dual eligible) receives services in a Level I Sub-acute facility that is not Medicare certified. Non-Medicare certified facilities should only be utilized for dual eligibles when a Medicare certified facility is not available.

In an emergency situation, the provider must first provide any medically necessary covered behavioral health services and then coordinate payment with any potential third party payers.

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Providers must cost avoid all claims or services that are subject to third party payment and may deny a service to a person if providers know that the third party payer is financially responsible for providing the service. RBHAs may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to the RBHA. However, if the provider knows that the third party payer will not pay for or provide a medically necessary covered service, then the provider must not deny the service nor require a written denial letter. If the provider does not know whether a particular medically necessary covered service is covered by the third party payer, the provider must contact the third party payer rather than requiring the person receiving services to do so. Providers must refer to the formulary of the behavioral health recipients' Medicare Part D plan to determine if a specific drug will be covered under Medicare Part D. The Medicare Part D plan formularies are available at www.medicare.gov.

3.5.7-D: Discovery of third party liability after services were rendered or reimbursed

If it is determined that a person has third party liability after services were rendered or reimbursed, behavioral health providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the behavioral health provider must submit an adjustment to the original claim, including a copy of the Remittance Advice or the Explanation of Benefits. AHCCCS and/or ADHS/DBHS may refer cases to the T/RBHA for Title XIX and Title XXI persons in the following circumstances:

- Uninsured/under-insured motorist insurance
- Tortfeasors
- Special Treatment Trusts
- Adoptions
- Worker's compensation
- Estates

The behavioral health provider is responsible to report any cases involving the above circumstances to the T/RBHA. Behavioral health providers may be asked to cooperate with AHCCCS and/or ADHS/DBHS in third party collection efforts. Magellan will contact providers and request specific information when required. Providers can reach Magellan with this information at 800-564-5465

3.5.7-E: Co-payments, premiums, coinsurance and deductibles

If a third-party insurer requires a person to pay a co-payment, coinsurance or deductible, the T/RBHA is responsible for covering those costs for Title XIX/XXI eligible persons (see [PM Attachment 3.5.1, Third Party Liability and Coordination of Benefits, Title XIX/XXI Eligible Persons](#); see subsections 3.5.7-G and 3.5.7-H for specific cost sharing responsibilities for behavioral health recipients with Medicare Part A, B and D).

Non-Title XIX/XXI persons determined to have a Serious Mental Illness who have Third Party Liability

The ADHS/DBHS co-payment assessed for non-Title XIX/XXI persons determined SMI is intended to be payment by the member for services covered in the medication only benefit (e.g., psychiatric assessments, medication management, medications), but co-payments are **only**

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collected at the time of the psychiatric assessment and psychiatric follow up appointments. Non-Title XIX/XXI persons determined to have a Serious Mental Illness may be assessed the ADHS/DBHS co-payment in accordance with [PM Section 3.4, Co-payments](#), or may be assessed co-payments, premiums, coinsurance and/or deductibles for services covered by the third party insurer. When a Non-Title XIX/XXI person determined to have SMI is assessed the ADHS/DBHS co-payment, he/she will pay the ADHS/DBHS co-payment or the co-payment required by the third party insurer, whichever is less (see [PM Attachment 3.5.2, Third Party Liability and Coordination of Benefits, Non-Title XIX/XXI Eligible Persons Determined to have a Serious Mental Illness](#)). Additionally, when a Non-Title XIX/XXI person determined to have SMI is assessed a co-payment for a generic medication that is also on the ADHS/DBHS Non-Title XIX/XXI Formulary, he/she will pay the ADHS/DBHS co-payment or the co-payment required by the third party insurer, whichever is less. T/RBHAs are responsible for covering the difference between the ADHS/DBHS co-payment and the third party co-payment when the third party co-payment is greater than the ADHS/DBHS co-payment. Behavioral health recipients are responsible for third party co-payments for services that are not services that ADHS/DBHS covers (see [ADHS/DBHS Guidelines to the RBHAs and Providers for Services to Non-Title XIX Members with Serious Mental Illness](#)) and third party premiums, coinsurance and deductibles, if applicable. When Non-Title XIX/XXI persons determined to have SMI have difficulty paying co-payments, the provider must re-screen the individual for Title XIX/XXI eligibility.

3.5.7-F: Transportation

Behavioral health providers must provide and retain fiscal responsibility for transportation for Title XIX and Title XXI persons in order for the person to receive a covered behavioral health service reimbursed by a third party, including Medicare.

3.5.7-G: Medicaid eligible persons with Medicare Part A and Part B

A Title XIX eligible person may receive coverage under both Medicaid (AHCCCS) and Medicare. These persons are sometimes referred to as “dual eligibles”. In most cases, behavioral health providers are responsible for payment of Medicare Part A and Part B coinsurance and/or deductibles for covered services provided to dual eligible persons. However, there are different cost sharing responsibilities that apply to dual eligible persons for a variety of situations. In the event that a Title XIX eligible person also has coverage through Medicare, behavioral health providers must ensure adherence with the requirements described in this subsection.

Persons who are eligible for Medicare benefits can receive services through one of the following arrangements:

- Fee-for-service Medicare system; or
- Enroll in a Medicare Advantage Plan.

A Medicare Advantage Plan is a managed care entity that has a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries.

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Medicare Part A and Part B cost sharing responsibilities for persons enrolled in a Medicare Advantage Plan

ADHS/DBHS is the payer of last resort. Therefore, if a behavioral health recipient is enrolled with a Medicare Advantage Plan, the behavioral health recipient must be directed to his/her Medicare Advantage Plan. However, if the Medicare Advantage Plan does not authorize a Title XIX covered behavioral health service, the behavioral health provider/Provider Network Organization (PNO) must:

- Review the requested service;
- Determine if the service is a medically necessary covered service; and
- When determined, provide the Title XIX covered behavioral health service not covered by Medicare Part A or B.

Behavioral health provider/PNO have cost sharing responsibility for all Title XIX covered services provided to behavioral health recipients by a Medicare Advantage Plan. For those Medicare services that have benefit limits, the Behavioral health provider/PNO must reimburse all Title XIX and Medicare covered services when the behavioral health recipient reaches the Medicare Advantage Plan's benefit limits.

Behavioral health provider/PNO only have cost sharing responsibility for the amount of the behavioral health recipient's coinsurance, deductible or co-payment. Behavioral health provider/PNO have no cost sharing obligation if the Medicare payment exceeds the Behavioral health provider/PNO contracted rate for the services. The behavioral health provider/PNO liability for cost sharing plus the amount of Medicare's payment must not exceed the behavioral health provider/PNO contracted rate for the service. With respect to co-payments, the behavioral health provider/PNO may pay the lesser of the co-payment or their contracted rate.

QMB duals enrolled in a Medicare Advantage Plan

QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. When a behavioral health recipient is enrolled in a Medicare Advantage Plan, the behavioral health provider/PNO is responsible for cost sharing for Medicare Part A and Part B services that are not covered under Title XIX, or differ in scope or duration. These Medicare services include:

- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

Non-QMB duals enrolled in a Medicare Advantage Plan

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The behavioral health provider/PNO is responsible for Part A and Part B cost sharing for Title XIX only covered services for Non-QMB duals.

Prior authorization for persons enrolled in a Medicare Advantage Plan

If the T/RBHA's contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, the T/RBHA is not obligated to pay the Medicare Part A or Part B cost sharing for Title XIX covered services, except for emergency services.

If the Medicare Advantage Plan determines that a service is medically necessary, the behavioral health provider/PNO is responsible for Medicare Part A and Part B cost sharing, even if the behavioral health provider/PNO determines otherwise. If the Medicare Advantage Plan denies a service requiring prior authorization for lack of medical necessity, the behavioral health provider/PNO must apply its own authorization criteria and may not use the Medicare Advantage Plan's decision as the basis for denial.

Out of network services for persons enrolled in a Medicare Advantage Plan

If an out of network referral is made by a contracted behavioral health provider and the T/RBHA specifically prohibits out of network referrals in the provider contract, then the behavioral health provider may be considered to be in violation of the contract and the T/RBHA has no Part A or Part B cost sharing obligation. The behavioral health provider who referred the behavioral health recipient to an out of network provider is obligated to pay any Part A or Part B cost sharing. The behavioral health recipient must not be responsible for the Medicare Part A or Part B cost sharing, unless the behavioral health recipient has been advised of the T/RBHA's network and elects to go out of the network. In this case, the behavioral health recipient is responsible for paying the Medicare Part A and Part B cost sharing amount, unless the service is an emergency, pharmacy (not Medicare Part D) or other physician ordered service.

If the Medicare Advantage Plan and the T/RBHA have networks for the same service that have no overlapping providers and the T/RBHA chooses not to have the service performed in its own network, then the T/RBHA is responsible for Part A and Part B cost sharing for that service. If the overlapping providers have closed their panels and the behavioral health recipient goes to an out of network provider, then the T/RBHA is also responsible for Part A and Part B cost sharing.

Medicare Part A and Part B pharmacy and other physician ordered services for persons enrolled in a Medicare Advantage Plan

The requirements described under this heading are for information purposes only. Behavioral health providers may or may not have direct responsibilities related to these activities.

For purposes of this subsection, "in the T/RBHA network" refers to the provider who supplies the prescription, not the prescribing provider. T/RBHAs must cover pharmacy co-payments for medications prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. However, if a provider prescribes a non-formulary medication, then the T/RBHA may opt to not reimburse for the prescription co-

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payment. If a T/RBHA requires prior authorization for formulary medications, then the T/RBHA may choose not to cover the co-payment if prior authorization was not obtained.

If a behavioral health recipient exceeds their pharmacy benefit limit, the T/RBHA must cover all prescription costs for the person. These prescriptions are subject to the T/RBHA's formulary, prior authorization and pharmacy network requirements.

If the Medicare Advantage Plan does not offer a pharmacy benefit, then the T/RBHA may require that the prescribing physician be in the T/RBHA's network for prescription benefit coverage. This requirement extends to all prescribed services (e.g., laboratory services).

Cost sharing responsibilities for persons under the Medicare fee-for-service program

A Medicare beneficiary may elect to receive Medicare services through providers authorized to deliver Medicare services. Behavioral health provider/PNO have Part A and Part B cost sharing responsibility for Title XIX covered services provided to behavioral health recipients by fee-for-service behavioral health providers in the T/RBHA's network. Behavioral health provider/PNO have no Part A and Part B cost sharing obligation if the Medicare payment exceeds the behavioral health provider/PNO contracted rate for the services. The behavioral health provider/PNO liability for Part A and Part B cost sharing plus the amount of Medicare's payment must not exceed the behavioral health provider/PNO contracted rate for the service. For those Medicare services for which prior authorization is not required, but are also covered under Title XIX, there is no Part A or Part B cost sharing obligation if the T/RBHA has a contract with the provider and the provider's contracted rate includes Medicare Part A and Part B cost sharing as specified in the contract.

QMB duals receiving services under the Medicare fee-for-service program

QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

The behavioral health provider/PNO is responsible for the payment of the Medicare Part A and Part B deductible and coinsurance for Title XIX covered services. In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. The services must be provided regardless of whether the behavioral health provider is in the T/RBHA's network. These Medicare services include:

- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

Non-QMB duals receiving services under the Medicare fee-for-service program

The behavioral health provider/PNO is responsible for the payment of the Medicare Part A and Part B deductible and coinsurance for Title XIX covered services that are rendered on a fee-for-

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service basis by a Medicare behavioral health provider within the RBHA's network. Behavioral health provider/PNO are not responsible for Medicare Part A and Part B services not covered under Title XIX.

Prior authorization for persons receiving services under the Medicare fee-for-service program

If the T/RBHA's contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, the T/RBHA is not obligated to pay the Medicare Part A and Part B cost sharing for Title XIX covered services, except for emergency services. The T/RBHA cannot require prior authorization for Medicare Part A and Part B only services.

If the Medicare provider determines that a service is medically necessary, the behavioral health provider/PNO is responsible for Medicare Part A and Part B cost sharing, even if the behavioral health provider/PNO determines otherwise. If Medicare denies a Part A or Part B service requiring prior authorization for lack of medical necessity, the behavioral health provider/PNO must apply its own authorization criteria. If the criteria supports the provision of the Part A or Part B service, the behavioral health provider/PNO must cover the cost of the service.

Out of network services for persons receiving services under the Medicare fee-for-service program

If an out of network referral is made by a contracted behavioral health provider and the T/RBHA specifically prohibits out of network in the provider contract, then the behavioral health provider may be considered to be in violation of the contract and the T/RBHA has no Part A or Part B cost sharing obligation. The behavioral health provider who referred the behavioral health recipient to an out of network provider is obligated to pay any Part A or Part B cost sharing. The behavioral health recipient must not be responsible for the Medicare Part A or Part B cost sharing, unless the behavioral health recipient has been advised of the T/RBHA's network and elects to go out of the network. In this case, the behavioral health recipient is responsible for paying the Medicare Part A and Part B cost sharing amount, unless the service is an emergency, pharmacy (not Medicare Part D) or other physician ordered service.

Medicare Part A and Part B pharmacy and other physician ordered services for persons receiving services under the Medicare fee-for-service program

The requirements described under this heading are for information purposes only. Behavioral health providers may or may not have direct responsibilities related to these activities.

T/RBHAs must cover prescriptions and other ordered services that are both prescribed and filled by in network providers. If a provider prescribes a non-formulary prescription, then the T/RBHA may opt to not reimburse for the prescription. The T/RBHA may also require prior authorization.

For information on prior authorization, refer to [section 3.14, Securing Services and Prior Authorization](#).

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3.5.7-H: Medicare Part D Prescription Drug Coverage

Beginning on January 1, 2006, all persons eligible for Medicare Part A or enrolled in Medicare Part B became eligible for Medicare Part D Prescription Drug coverage. Dual eligible persons (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid. To access Medicare Part D coverage, persons must enroll in either a Prescription Drug Plan (PDP – fee-for-service Medicare) or a Medicare Advantage-Prescription Drug Plan (MA-PD – managed care Medicare).

Cost sharing responsibilities for persons in a Medicare Part D PDP or MA-PD

The Medicare Part D Prescription Drug standard coverage includes substantial cost sharing requirements, which include monthly premiums, an annual deductible and co-insurance (see the [Part D Voluntary Prescription Drug Benefit Program Benefits and Costs for People with Medicare](#)).

Persons with limited income and resources may be eligible for the Limited Income Subsidy (LIS) or “extra help” program (see the [Social Security Administration](#) for income and resource requirements). With this “extra help”, all or a portion of the persons’ cost sharing requirements are paid for by the federal government. Dual eligibles and behavioral health recipients on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other persons have to apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. T/RBHAs may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D co-payments for Non-Title XIX/XXI persons determined to have SMI, as described in subsection 3.5.7-E.