Section: 2 Chapter: 700
Policy: 701, Third Party Liability and Coordination of Benefits

1. PURPOSE:

The purpose of this policy is to describe requirements for coordinating benefits of Tribal/Regional Behavioral Health Authority (T/RBHA) enrolled individuals who have third party insurance coverage or other third party payment sources. This policy covers the following requirements: Determining third party health insurance coverage before using Federal or State funds; coordinating services and assigning benefit coverage to third party payers when information regarding the existence of third party coverage is available; submitting 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; coordinating benefits for persons enrolled with Medicare Part A, Part B, and/or Part D; and coordinating benefits for persons enrolled in a qualified health plan through the federal health insurance exchange.

2. TERMS:

Definitions for terms are located online at http://www.azdhs.gov/bhs/policy/index.php.
The following terms are referenced in this section:

Cost avoidance
Cost sharing
Dual eligible
Explanation of Benefits
Fee for Service
In-network services
Medicare Part A
Medicare Part B
Medicare Part C
Medicare Part D
Non-QMB Dual
Out of network services
Qualified Medicare Beneficiary (QMB) Dual
Remittance Advice
Serious Mental Illness
Third Party Liability

3. PROCEDURES:

a. 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.
   i. 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.

ii. Behavioral health providers must inquire about a person's other health insurance coverage during the initial appointment or intake process. 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 AHCCCS' automated eligibility verification systems. 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.

b. 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.

i. 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.

ii. When coverage from a third party payer has been verified, there are two methods used in the coordination of benefits:

(1) Cost avoidance-Behavioral health providers must cost avoid all claims or services that are subject to third-party payment. 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.

(2) 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.

iii. 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 Policy Attachment 701.1,).

iv. 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.

c. 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 Office of Program Support Operations and 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:
   i. 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:
      (1) 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;
      (2) When it is determined that the person had relevant third party coverage after services were rendered or reimbursed;
      (3) When a behavioral health recipient eligible for both Medicaid and Medicare (dual eligible) receives services in a Behavioral Health Inpatient facility that is not Medicare certified. Non-Medicare certified facilities may be utilized for dual eligibles when a Medicare certified facility is not available; or
      (4) When a behavioral health recipient is receiving covered services from a preferred provider (i.e., the provider is close to person's home) and the provider is unable to bill the person's third party payor.
   ii. 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. This policy permits the denial of *claims payment* based upon third party payment sources, but must not be interpreted to permit the denial of *services or service coverage* based upon third party payment sources. T/RBHAs and T/RBHA providers may not employ cost avoidance strategies that limit or deny a person eligible for behavioral health services from receiving timely, clinically appropriate, accessible, medically necessary covered services.
   iii. 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:
(1) Uninsured/underinsured motorist insurance
(2) Restitution Recovery
(3) First-and third-party liability insurance
(4) Worker's Compensation
(5) Tort feasors, including casualty
(6) Estate Recovery
(7) Special Treatment Trust Recovery

iv. 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.

d. Behavioral health providers are responsible for identifying whether members are enrolled in Medicare Part A or Medicare Part B and covering services accordingly. Medicaid eligible persons with Medicare Part A, Part B, and/or Part D:
   i 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.
   ii Some dual eligible AHCCCS members may have Medicare Part B only. As these members do not have Medicare Part A, Medicaid is the primary payer for services which generally would be covered under Part A including hospitalizations, skilled nursing facilities, and hospice. A claim should not be denied for a lack of Medicare Explanation of Benefits (EOB) when the member is not enrolled in Medicare Part A.
   iii In the same way, if members have Medicare Part A only, Medicaid is the primary payer for services which are generally covered under Part B including physician visits and durable medical equipment.
   iv 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.
      (1) QMB Duals are entitled to all AHCCCS and Medicare Part A and B covered services. RBHAs are responsible for payment of Medicare cost sharing for all Medicare covered services regardless of whether the services are covered by AHCCCS. The RBHA only has responsibility to make payments to providers registered with AHCCCS to provide services to AHCCCS eligible members. The payment of Medicare cost sharing must be provided regardless of whether the provider is in the RBHA's network or prior authorization has been obtained.

QMB Dual Cost Sharing Matrix

Covered Services	RBHA Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	Cost sharing responsibility only	YES	YES
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	YES
Emergency Services	Cost sharing responsibility only	YES	YES

*Subject to RBHA Policy

(2) The Contractor is responsible for the payment of the Medicare cost sharing for AHCCCS covered services for Non-QMB Duals that are rendered by a Medicare provider within the Contractor's network.

Non-QMB Dual Cost Sharing Matrix

Covered Services	T/RBHA Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	No cost sharing responsibility	NO	NO
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES*	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	NO*
Emergency Services	Cost sharing responsibility only	YES	YES

*Unless authorized by the RBHA

v Limits on cost sharing:
(1) The Contractor shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service. There is no cost sharing obligation if the Contractor has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing.
(2) The exception to these limits on payments as noted above is that the Contractor shall pay 100% of the member copayment amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

vi The Contractor can require prior authorization, but if the Medicare provider determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If Medicare denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Contractor shall cover the cost of the service.

vii For QMB Dual members, the Contractor has cost sharing responsibility regardless of whether the services were provided by an in or out of network provider. For AHCCCS covered services rendered by an out of network provider to a non-QMB Dual, the Contractor is not liable for any Medicare cost sharing unless the Contractor has authorized the member to obtain services out of network. If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the Contractor is not responsible for paying the Medicare cost sharing amount.

viii Cost sharing and coordination of benefits for persons enrolled in Medicare Part D:
(1) Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D.
(2) T/RBHAs will utilize available Non-Title XIX/XXI funds to cover Medicare Part D co-payments for Title XIX/XXI and Non-Title XIX/XXI persons determined to have SMI, with the following limitations:
(a) Co-payments are to be covered for medications on the ADHS/DBHS Behavioral Health Drug List.
(b) Co-payments are to be covered for medications prescribed by T/RBHA in-network providers.
(3) T/RBHAs may utilize Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap.
(4) If a request for an exception has been submitted and denied by the Medicare Part D plan, the T/RBHA may utilize Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons determined SMI, regardless of Title XIX/XXI eligibility.

e. TRBHAs and TRBHA contracted providers:

i AHCCCS has liability for payment of benefits after Medicare and all other third party payer benefits have been paid. The TRBHA shall determine the extent of a recipient's third party coverage and bill all private insurance carriers and Medicare, including HMOs, prior to billing AHCCCS. AHCCCS maintains a record of each recipient's coverage by Medicare and private carriers. If a recipient's record indicates third party coverage but no Medicare and/or insurance payment is indicated on the claim, the claim may be denied.

ii TRBHA contracted providers must determine the extent of the third party coverage and bill Medicare and all private insurance carriers, including HMOs, prior to billing AHCCCS. If a recipient's record indicates third party insurance coverage but no Medicare and/or insurance payment is indicated on the claim, the TRBHA contracted provider's claim may be denied.

iii RBHAs and RBHA contracted providers must educate and encourage Non-Title SMI members to enroll in a qualified health plan through the federal health insurance exchange and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. The following applies for members who enroll in a qualified health plan through the federal insurance exchange:

(1) Members enrolled in a qualified health plan through the federal health insurance exchange continue to be eligible for Non-Title XIX covered services that are not covered under the exchange plan.

(2) Non-Title XIX funds may not be used to cover premiums or co-pays associated with qualified health plans through the federal exchange or other third party liability premiums or co-pays other than Medicare Part D for SMI members.

(3) RBHAs must issue approval prior to any utilization of Non-Title XIX funding for services otherwise covered under a qualified plan through the federal exchange.

5. REFERENCES:

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 Office of Program Support Operations and Procedures Manual

6. APPROVED BY:

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