

Arizona Department of Health Services

Division of Behavioral Health Services

PROVIDER MANUAL

Section 7.2 Medical Institution Reporting for Medicare Part D

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7.2.1 Introduction

Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI) receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Medicare Part D coverage includes co-payment requirements of all persons. However, Medicare Part D co-payments are waived when a dual eligible person enters a medical institution, that is Medicaid funded, for at least a full calendar month. Medical institutions must notify AHCCCS when a dual eligible person is expected to be in the medical institution for at least a full calendar month to ensure co-payments for Part D are waived. The waiver of co-payments applies for the remainder of the calendar year, regardless of whether the person continues to reside in a medical institution. Given the limited resources of many dual eligible persons and to prevent the unnecessary burden of additional co-pay costs, it is imperative that these individuals are identified as soon as possible.

7.2.2 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 423.4](#)
- [42 CFR 423.104](#)
- [9 A.A.C. 20](#)
- [AHCCCS/ADHS Contract](#)
- [ADHS/RBHA Contracts](#)
- [ADHS/TRBHA IGAs](#)
- [ADHS/DBHS Covered Behavioral Health Services Guide](#)
- [Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding](#)

7.2.3 Scope

To whom does this apply?

This section applies to all facilities designated as a medical institution (provider types 02, 71, 78, B1, B2, and B3).

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7.2.4 Did you know...?

Enrollees with Medicare Part D prescription drug coverage and AHCCCS (health insurance and Medicare Savings Programs), dual eligibles, have minimal prescription drug co-payments. Part D co-payments will be waived when dual eligible persons enter an institution with the intent to remain for at least a full calendar month.

7.2.5 Definitions

[Dual Eligible](#)

[Institutionalized individual](#)

[Medicare Advantage Prescription Drug Plan \(MA-PD\)](#)

[Medical Institution](#)

[Prescription Drug Plan \(PDP\)](#)

7.2.6 Objectives

To inform behavioral health providers designated as medical institutions of reporting and tracking requirements for dual eligible persons to ensure Medicare Part D co-pays are waived.

7.2.7 Procedures

7.2.7-A: Reporting requirements

To ensure that dual eligible persons' Medicare Part D co-payments are waived when it is expected that dual eligible persons will be in a medical institution, funded by Medicaid, for at least a full calendar month, AHCCCS must be notified immediately upon admittance.

Reporting must be done using [PM Form 7.2.1, AHCCCS Notification To Waive Medicare Part D Co-Payments For Members In A Medical Institution That Is Funded By Medicaid](#). Providers must not wait until the person has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Persons who have Medicare Part "B" only;
- Persons who have used their Medicare part "A" lifetime inpatient benefit; and
- Persons who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical Institutions

Medical institutions include the following behavioral health providers:

- Acute Hospital (PT 02)
- Psychiatric Hospital – IMD (PT 71)
- Residential Treatment Center – IMD (PT B1, B3)
- Residential Treatment Center – Non IMD (PT 78, B2)

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What must be done when a Title XIX eligible person is admitted to an IMD?

At the time of admission, IMD designated providers (provider type 71 and B6) must give written notification to Title XIX eligible persons (ages 21-64) that their AHCCCS eligibility will end if they remain in an IMD longer than 30 days per admission or 60 days annually (July 1- June 30).

NARBHA's IMD providers forward their Daily AHCCCS Admission Discharge Reports to NARBHA for entry into the NARBHA tracking report. These reports are sent to NARBHA every day (Monday-Friday) no later than noon. Utilization is entered into the NARBHA IMD Tracking Report and given to the NARBHA Adult System of Care Coordinator for review no later than three o'clock each day.

A person's Clinical Liaison needs to ensure that discharge planning starts at the time of admission to an IMD. The discharge plan must address what will happen if the person reaches the 30-day limit, such as the person would be transferred to a psychiatric unit of a general medical hospital or other non-IMD facility to avoid losing Title XIX eligibility. This is especially critical for persons who may also have a medical condition that could be jeopardized by the loss of Title XIX medical benefits.

The Arizona State Hospital must notify AHCCCS Division of Member Services fax: (602) 253-4807 or telephone: (602) 417-4063 of all admissions of Title XIX and Title XXI eligible persons at the time of admission.

IMDs, other than the Arizona State Hospital, must notify AHCCCS Division of Member Services fax: (602) 253-4807 or telephone: (602) 417-4063 when a Title XIX eligible person (ages 21-64) has been a resident for 30 consecutive days. IMDs must be prepared to provide the following information:

- Provider identification number and telephone number;
- Behavioral health recipient's name, date of birth, AHCCCS identification number and social security number; and
- Date of admission.

What happens if a Title XIX eligible person (ages 21-64) stays longer than 30 days?

Reimbursement for stays exceeding 30 days per admission or 60 days per contract year (July 1- June 30) cannot be made with Title XIX or Title XXI dollars.

What happens when a Title XIX eligible person (ages 21-64) who has exceeded 30 days is discharged?

AHCCCS eligibility for a person whose admission has been reported as exceeding 30 days will be suspended for the remainder of the admission. IMD providers must notify AHCCCS Division of Member Services when the person is discharged so that the person's eligibility can be restored.

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Are there tracking requirements for IMD providers?

Because of claims and encounter lags, tracking of utilization at the state level (AHCCCS and ADHS) is not always up to date. IMD providers are encouraged to review utilization information with the contracted RBHA and from a person's history, medical records and any other resources to facilitate the tracking of Title XIX eligible (ages 21-64) persons' accumulated days in an IMD setting.

When a NARBHA member presents at an IMD facility, the IMD agency staff contacts a NARBHA Member Representative at a designated phone number, (928) 214-1177, to determine the total number of IMD days available to that member.

Authorization for IMD services is handled by the case management agency with which the member is enrolled.

The IMD facility completes and faxes the TXIX Funding Source Eligibility Notification Form to NARBHA on the beginning and ending date of when TXIX funds are used as payment for IMD services.

Faxes to NARBHA are sent on a daily basis to the Senior Office Specialist/IMD tracking at a designated fax number

The NARBHA Adult System of Care Coordinator tracks and notifies the IMD agency when a member's length of stay (LOS) is ≥ 23 days, or ≥ 53 days, as is determined from A above.

When a member's stay could exceed the IMD days available, decisions on the placement are addressed by the treatment team/case management agency responsible for the member.

If a TXIX member is approaching his/her IMD benefit limit, and the member still meets medically necessary continued stay criteria, then TGC/WYGC will plan for a transfer to a non-IMD facility either in the network (Community Counseling Centers or Mohave Mental Health Clinics) or out of the network, e.g. Flagstaff Medical Center Behavioral Health Unit, depending on whichever the referring facility believes serves the best psychiatric/medical interest of the member.

The receiving facility's admitting psychiatrist/CNP must concur with the continued stay determination.

The referring facility is responsible for transportation to the receiving facility upon admission and from the receiving facility upon discharge.

Are there reporting requirements for dual eligible persons enrolled in Medicare Part D who are admitted to an IMD?

To ensure that dual eligible persons' Medicare Part D co-payments are waived when it is expected that dual eligible persons will be in an IMD, funded by Medicaid, for at least a full calendar month, AHCCCS must be notified immediately upon admittance. Reporting must be done using [PM Form 3.21.1](#), AHCCCS Notification To Waive Medicare Part D Co-Payments For

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Members In A Medical Institution That Is Funded By Medicaid, included in [Section 3.21](#), Service Prioritization for Non-Title XIX/XXI Funding.