CHAPTER 5:

Quality Management

Reviewed/Revised: 10/1/18, 3/4/19, 1/1/20

5.0 HEALTH CHOICE ARIZONA QUALITY MANAGEMENT OVERVIEW

Health Choice Arizona's Quality Management (QM) Program centers on continuous quality improvement (CQI), through the plan-do-study-act cycle (PDSA), and monitors, evaluates and improves the continuity, quality, accessibility and availability of health care and services provided to Health Choice Arizona's members. Health Choice Arizona conducts P erformance Improvement Projects (PIPs) that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non- clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Health Choice Arizona maintains a formal process for peer review to analyze issues involving quality of care (QOC) issues arising from the activities of providers for the purpose of improving the quality of the Health Choice Arizona provider network and the quality of care received by Health Choice Arizona members.

The QM program also provides the foundation by which member issues regarding care or service will be evaluated and improved for the benefit of the member, the practitioner, and Health Choice Arizona in order to meet or exceed both the internal and external customer expectations. The credentialing and recredentialing program ensures the delivery of quality health care services to members through the review of participating network provider files against national credentialing standards.

5.1 PERFORMANCE MEASURES

Health Choice Arizona maintains clinical and service improvement projects/activities that relate to key national measurements of quality; and utilizes data that is statistically valid, reliable, clearly defined and comparable over time. Performance measures provide a structured framework in which to target and concentrate clinical and service efforts. Providers must comply with reporting requirements supporting calculation of performance measures and other quality reporting. Providers are required to meet each established performance measure below, and implement activities to improve measures not achieving the minimum performance standards.

ACC MEASURES	MINIMUM PERFORMANCE STANDARDS
ADULT MEASURES	
Inpatient Utilization (IPU) - All Ages	33 Per 1000 Member Months

Ambulatory Care - ED Utilization (AMB) - All Ages	58 Per 1000 Member Months
Plan All-Cause Readmissions (PCR)	14%
Breast Cancer Screening (BCS)	55%
Cervical Cancer Screening (CCS)	53%
Chlamydia Screening in Women (CHL)	57%
Colorectal Screening (COL)	65%
CDC - HbA1c Testing	86%
CDC - HbA1c Poor Control (>9.0%)	43%
CDC - Eye Exam	55%
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 Days of Enrollment (PPC)	80%
Timeliness of Prenatal Care: Postpartum Care Rate (PPC)	64%
Contraceptive Care – Post-Partum Women Ages 21-44	Baseline Measurement Year*
Mental Health Utilization (MPT) - All Ages	Baseline Measurement Year*
Use of Opioids From Multiple Providers (UOP)	Baseline Measurement Year*
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Baseline Measurement Year*
Follow-Up After Hospitalization for Mental Illness, (FUH) - 7 Days, 30 Days (Adult/Children)	7 Days-85% 30 Days-95%
Use of Opioids From Multiple Providers (UOP)	Baseline Measurement Year*
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Baseline Measurement Year*
Concurrent Use of Opioids and Benzodiazepines	Baseline Measurement Year*
Follow-Up after Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence Mental Illness (FUA)	Baseline Measurement Year*
CHILDRENS MEASURES	
CRS-Identified Member Initial Visit (within 30 days)	TBD
Children's Access to PCPs (CAP), by age: ***12-24 mo.***	95%
Children's Access to PCPs (CAP), by age: ***25 mo.- 6 yrs.***	87%
Children's Access to PCPs (CAP), by age: ***7 - 11 yrs.***	90%

Children's Access to PCPs (CAP), by age: ***12 - 19 yrs.***	89%
Well-Child Visits (W15): ***15 mo.***	62%
Well-Child Visits (W34): ***3 - 6 yrs.***	66%
Adolescent Well-Care Visits (AWC): ***12–21 yrs.***	41%
Annual Dental Visits (ADV): (**ages 2-20**)	60%
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	46%
Dental Sealants for Children Ages 6-9 at Elevated Caries Risk (SEAL)	Baseline Measurement Year*; CMS will be establishing MPS
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	Baseline Measurement Year*
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Baseline Measurement Year*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Baseline Measurement Year*
CHILDHOOD IMMUNIZATION STATUS	
DTaP	76%
IPV (1)	88%
MMR (1)	89%
Hib (1)	88%
HBV (1)	88%
VZV (1)	88%
PCV (1)	77%
Hepatitis A (HAV) (1)	85%
Rotavirus (1)	65%
Influenza (1)	45%
Combination 3 (4:3:1:3:3:1:4) (2)*	68%
ADOLESCENT IMMUNIZATIONS	
Adolescent Meningococcal	85%
Adolescent Tdap/Td	85%
Human Papillomavirus Vaccine (HPV)	25%
Adolescent Combination 1	85%
Combination 2	21%

Measure	MINIMUM PERFORMANCE STANDARDS
ACUTE PERFORMANCE MEASURES – RESERVE STATUS *	
Adults' Access to Preventive/ Ambulatory Health Services (AAP)	75%
Flu Vaccinations for Adults (FVA) - Ages 18-64yrs.	50%
Diabetes Admissions, Short-Term Complications (PQI-01)	244 Per 100,000 Member Months
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	1152 Per 100,000 Member Months
Asthma in Younger Adults Admissions (PQI-15)	119 Per 100,000 Member Months
Heart Failure Admission Rate (PQI-08)	278 Per 100,000 Member Months
EPSDT Participation	68%
Developmental Screening in the First Three Years of Life	55%
Weight Assessment and counseling - Body Mass Index (BMI) Assessment for Children/ Adolescents (WCC)	55%
Access to Behavioral Health Services, 7 Days - Measure Tabled Until Further Notice	75%
Access to Behavioral Health Services, 23 Days - Measure Tabled Until Further Notice	90%

MEASURE	MINIMUM PERFORMANCE STANDARD
RBHA GMH/SU PERFORMANCE MEASURES	
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence (FUA) – 7 Days, 30 Days	Baseline Measurement Year*
Follow-Up After Hospitalization for Mental Illness, (FUH), 7 Days, 30 Days: Ages 6-20 years, 21 years and older	7 Days - 60% 30 Days - 85%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Baseline Measurement Year*
Mental Health Utilization (MPT) – All Ages	TBD*
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	2%

Use of Opioids at High Dosage in Persons Without Cancer (OHD)	TBD*
Note: *AHCCCS will develop Minimum Performance Standards once baseline data has been analyzed for these measures.	

MEASURE	MINIMUM PERFORMANCE STANDARD
RBHA GMH/SU PERFORMANCE MEASURES RESERVE STATUS*	
Access to Behavioral Health Services, 7 Days- **Measure Tabled Until Further Notice**	75%
Access to Behavioral Health Services, 23 Days- **Measure Tabled Until Further Notice**	90%
Concurrent Use of Opioids and Benzodiazepines (COB)	Baseline Measurement Year*
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Baseline Measurement Year*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Baseline Measurement Year*

MEASURE	MINIMUM PERFORMANCE STANDARD
RBHA INTEGRATED PERFORMANCE MEASURES	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	85%
Ambulatory Care (AMB) - ED Utilization: All Ages	150 Per 1,000 Member Months
Annual Monitoring for Patients on Persistent Medications (MPM) – Combo Rate	87%
Asthma Medication Ratio (AMR): Ages 19-64 years	Baseline Measurement Year*
Breast Cancer Screening (BCS)	55%
Cervical Cancer Screening (CCS)	53%
Chlamydia Screening in Women (CHL): Ages 18-20 years, 21-24 years	57%
Colorectal Cancer Screening (COL)	65%
Comprehensive Diabetes Care – Eye Exam (CDC)	55%
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%) (HPC)	43%
Comprehensive Diabetes Care – HbA1c Testing (HbA1C)	86%
Concurrent Use of Opioids and Benzodiazepines (COB)	Baseline Measurement Year*
Contraceptive Care (CCP) – Post-Partum Women	Baseline Measurement Year*

Ages: 18-20 Years, 21-44 Years	
Follow-Up after Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence (FUA) – 7 Days, 30 Days	Baseline Measurement Year*
Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days, 30 Days: Ages 18-20 years, 21 years and older	7 Days - 60% 30 Days - 85%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Baseline Measurement Year*
Inpatient Utilization (IPU) General Hospital/Acute Care: All Ages	350 Days Per 1,000 Member Months
Mental Health Utilization (MPT): All Ages	TBD*
Plan All-Cause Readmissions (PCR)	23%
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 Days of Enrollment (PPC)	80%
Timeliness of Prenatal Care: Postpartum Care Rate (PPC)	64%
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	TBD*

RBHA INTEGRATED PERFORMANCE MEASURES RESERVE STATUS*	**MINIMUM PERFORMANCE STANDARD**
Access to Behavioral Health Services, 7 Days- **Measure Tabled Until Further Notice**	75%
Access to Behavioral Health Services, 23 Days- **Measure Tabled Until Further Notice**	90%
Asthma in Younger Adults Admission Rates (PQI 15)	20 Per 100,000 Member Months
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	90 Per 100,000 Member Months
Diabetes Short-Term Complications Admission Rate (PQI 01)	40 Per 100,000 Member Months
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	TBD**
EPSDT Participation: Ages 18- 21 Years	68%

Flu Vaccinations for Adults (FVA): Ages 18-64 years, 65 years and older	18-64 years - 50% 65 years and older – 75%
Heart Failure Admission Rate (PQI 08)	32 Per 100,000 Member Months
Percentage of Eligibles Who Received Preventative Dental Services (PDENT)	46%

One of Health Choice Arizona's strategies to collaborate and support providers with achieving the ultimate quality performance is through distributing Physician's Toolkits. These toolkits will be distributed to participating providers monthly via their network representative and will be a guide to help identify performance gaps and how to improve. Practitioner and provider performance data is used to monitor performance and close gaps across all domains of care. Both practitioners and providers agree to participate in quality improvement activities as per their contractual agreement with Health Choice Arizona.

These tools will range from a "Report Card" summary of their office, their paneled membership with their specific gaps in care called the "Member Roster," and an overview sheet to help bill the codes to get credit for the work that's completed. Additionally, a continued change is the administration of the Consumer Assessment of Healthcare Providers and Systems, CAHPS® for both adults and children. This annual consumer satisfaction survey is administered to a random sample of adult and child members. Results are aggregated and reported to health plans. The CAHPS® survey includes satisfaction on topics including but not limited to: rating of all health care, rating of personal doctor, getting appointments and care quickly, communication with personal doctor, coordination of health care services between primary and specialist care, to name a few. This survey is completed every other year and the next one is to be sent out in the beginning of FY2020.

5.2 PERFORMANCE IMPROVEMENT PROJECTS

Health Choice Arizona identifies quality improvement opportunities through continuous quality monitoring that takes place in every department and through departmental sharing of ideas for performance improvement. Quality Improvement opportunities are the result of input from internal and external sources, mainly from Arizona Medicaid regulatory office; direction from the QM/PIC; and follow-up actions from previous projects, trends identified from clinical and service quality performance indicators and analysis of age or gender specific diagnoses that occur frequently.

Additional sources include member and provider satisfaction surveys, utilization management reports, provider profiling data, peer review, on-site reviews of providers, complaints/grievances and appeals/disputes data, and Arizona Medicaid performance measures and trends. Quality Improvement opportunities may range from those targeted at individual system improvements or to those opportunities which are more on-going and result in the development of a Performance Improvement Project (PIP). A PIP, regulated by AHCCCS and carried out by Health

Choice Arizona, will measure performance in one or more focused areas; undertake system interventions to improve quality; and evaluate the effectiveness of those interventions. The project methodology includes: why the project was developed or the purpose of the project, why the project topic was chosen and the impact that it is expected to have on Health Choice Arizona members, what aspect of care the PIP addresses and what data will be used for analysis of the project. Our current PIP is E-Prescribing.

5.3 QUALITY OF CARE (QOC) AND SERVICE COMPLAINTS

QOC and service complaints are investigated by Health Choice Arizona Clinical Quality Management staff, assigned a substantiation rating, severity level and recommended intervention. Potential quality of care issues and complaints, identified through any internal or external referral source, may range from a member's allegation of medical care not meeting expectations to the identification of a potential deviation from the standard of care in the services rendered by a provider. Issues may involve specific patient cases or systems problems, which can impact patient care.

Providers are required to participate in Quality of Care investigations including but not limited to medical record requests, inquiry letters regarding allegations, and site visits by Clinical Quality Management staff. All requested information is for Quality Management purposes and kept confidential under ARS§36-2401 through 2404, ARS§36-441, ARS§36-445, and ARS§36-2917, ARS§ 36 – 445.01 and ARS§41-1959(C)(5).

All complaints regarding quality of care are tracked and trended in the QM database and those that indicate serious quality, utilization or risk management issues are flagged to be addressed by the Health Choice Arizona Medical Director (s) and/or through Health Choice Arizona's formalized peer review process. Resolution may include, for example, policy changes, education, corrective actions, process changes or additional monitoring.

The Health Choice Arizona Quality Management/Performance Improvement Committee (QM/PIC), chaired by the Health Choice Arizona Medical Director (s) or his/her designee provides oversight for the QM/PI Program and is responsible for the quality of care and peer review functions. Contracted physicians, representing a variety of medical specialties, serve on the Committee and are appointed by the Medical Director (s). If a provider issue is investigated by the QM/PIC and that particular specialty is not represented within the Committee, the QM/PIC may consult on an ad hoc basis with a peer from that specialty.

The Health Choice Arizona Quality Management Department strongly encourages a working relationship with providers and welcomes comments, questions, or suggestions. Network providers, contracted or affiliated, are able to participate and become engaged in quality improvement initiatives through involvement with the Health Plan's committees, survey participation, or directly on a one-to-one basis with the Health Choice Arizona Provider Performance Representative and/or with the CMO/Medical Director(s).

5.4 REPORTING OF INCIDENTS, ACCIDENTS AND DEATHS

Behavioral Health providers must report any incident, accident, or death as delineated below to Health Choice Arizona within 48 hours, via the AHCCCS Quality Management System (QMS) portal.

- Deaths;
- Medication error(s);
- Abuse or neglect allegation made about staff member(s);
- Suicide attempt;
- Self-inflicted injury;
- Injury requiring emergency treatment;
- Physical injury that occurs as the result of personal, chemical or mechanical restraint;
- Unauthorized absence from a licensed behavioral health facility, group home or HCTC of children or recipients under court order for treatment;
- Suspected or alleged criminal activity;
- Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202 (A) or (B); Incidents or allegations of violations of the rights as described in A.A.C. R9-20-203 or in A.A.C. R9-21, Article 2;
- Discrimination;
- Exploitation;
- Coercion;
- Manipulation;
- Retaliation for submitting complaint to authorities;
- Threat of discharge/transfer for punishment
- Treatment involving denial of food;
- Treatment involving denial of opportunity to sleep;
- Treatment involving denial of opportunity to use toilet;
- Use of restraint or seclusion as retaliation;
- Health Care-Acquired and Provider Preventable Conditions as described in the AHCCCS AMPM

5.5 REPORTING SECLUSION AND RESTRAINTS

As per AHCCCS AMPM Policy 962 Reporting Seclusion and Restraint, licensed behavioral health programs authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and information on the debriefing subsequent to the occurrence of seclusion or restraint to Health Choice Arizona's Quality Management Department within five (5) days of the occurrence. The individual reports must be submitted on the Seclusion and Restraint Reporting form. In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be attached to the Seclusion and Restraint Reporting. The face-to-face monitoring form must include the requirements as per 42 CFR 482.13, 42 CFR § 483 Subpart G, R9-20-602 and R9-21-204, outlined in Seclusion and Restraint Monitoring Requirements.

Health Choice Arizona will submit individual reports received from providers involving enrolled children and individuals determined to have a Serious Mental Illness to the Office of Human Rights. This will be done on a weekly or monthly basis, as arranged with the Office of Human Rights.

5.6 CREDENTIALING AND RECREDENTIALING PROGRAM

The principle obligation of the Health Choice Arizona Credentialing and Recredentialing Program is to promote the delivery of quality healthcare services to covered members by evaluating the training and experience of the participating healthcare providers. The Health Choice Arizona credentialing process does not discriminate against any health care professional solely on the basis of licensure or board certification, or on the basis of a health care professional servicing high risk populations or specializing in the treatment of costly conditions. The responsibility of credentialing and recredentialing process oversight is delegated directly to the CMO, Medical Director, or designee and to the Credentialing Committee, a subcommittee of the QM/PIC. The members of the Credentialing Committee consist of the CMO/Medical Director(s) or designee, QM Vice President, or designee, QM Credentialing Manager, and contracted Health Choice Arizona physicians with varied specialties of Primary Care, pediatrics, endocrinology, general surgery, etc.

In order to provide a thorough assessment and reassessment of the qualifications of Health Choice Arizona providers, the members of the Credentialing Committee shall, to the extent practical, have experience in and knowledge of the credentialing process and shall represent those medical and surgical specialties commonly found in the Health Choice Arizona Network. If you are interested in participating in the Credentialing Committee, please contact the Credentialing Manager at (480) 760-4919. When necessary, the CMO/Medical Director(s) and Credentialing Committee will consult with other provider types to advice on the credentials of providers in specialties not represented on the Committee or when additional peer review information is required.

Health Choice Arizona requires that all practitioners who are not hospital or emergency services based, or who are not employees of a contracted facility or are members of a delegated entity to be credentialed.

Health Choice Arizona is a member of the Arizona Association of Health Plans (AzAHP) credentialing alliance which is comprised of Arizona Managed Care Organizations (AHCCCS Program Contractors). Health plans participating in the Alliance agree to utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source for all practitioner credentialing applications and a common paper application for all facility credentialing applications. Participating health plans also developed a common practitioner data form and organizational data form to collect information necessary for their contract review process and system loading requirements.

On behalf of the participating plans, AzAHP has contracted with Aperture™ Credentials Verification Organization (CVO) for primary source verification (PSV) services for the alliance.

Aperture™ will perform the PSV once and share the results with each participating plan that you have authorized to receive it.

To follow are additional details related to the AzAHP credentialing alliance and some of the benefits that you can expect to see from it.

Practitioners and Facilities *currently* contracted with more than one of the participating plans

1. A single date will be established that allows one recredentialing process to satisfy the recredentialing requirement for each of the participating plans with which a provider is contracted. That date will be the earliest date that the provider is scheduled to be recredentialed by any of the participating plans. The next recredentialing date will be set three (3) years following the initial alliance recredentialing event.
2. For practitioner groups that are adding a new practitioner, complete the common Practitioner Data Form (found on the website of any participating plan) once and send to each of the participating plans which the group is contracted.

   Practitioners must also make sure CAQH is updated and each contracted, participating plan is approved to access the CAQH application.

Practitioners and Facilities *requesting* contracts with one or more of the participating plans

1. Complete the appropriate common data form (Practitioner or Organizational, found on the website of any participating plan) once and send to the participating plan(s) you wish to contract with.
2. Practitioners who are registered with CAQH are encouraged to make sure CAQH is updated and each of the participating plans that you wish to contract with is approved to access your CAQH application. Practitioners who are not currently registered with CAQH and Facilities will be contacted by the plan or Aperture™ regarding the need for a credentialing application.
3. If you are a practitioner that requires a site visit as part of the initial credentialing event (Primary Care Provider or Obstetrician) or a facility that requires a site visit as part of the initial credentialing event (facilities that are not accredited or surveyed), the participating plan(s) that you are requesting to contract with will have access to any site visit already performed under the alliance. If a site visit has already been performed by another participating plan in the AzAHP credentialing alliance, another site visit will not be necessary. If no site visit has been performed by a participating plan in the AzAHP credentialing alliance, a single site visit will be performed as part of the initial credentialing event and made available to all participating plans.

For practitioner groups that are adding a new practitioner, complete the common Practitioner Data Form (found on the website of any participating plan) once and send to each of the

participating plans you are contracted with. **Practitioners must also make sure CAQH is updated and each of the participating plans that you are contracted with is approved to access your CAQH application**.

The CAHQ application requires that the provider document the following information: Reasons for inability to perform the essential functions of the position, with or without accommodation; history of substance abuse, including illegal drug use; history of loss of license and/or felony convictions; history of loss or limitations of privileges or disciplinary activities; attestation by the applicant of the correctness and completeness of the application; a copy of the current license to practice; a copy of a valid DEA certificate (if applicable); a copy of a current malpractice insurance liability certificate, with a minimum of $1million/$2 million coverage; a current curriculum vitae (CV); a copy of the ECFMG, if applicable; written explanations regarding any sanction activity, malpractice.

Judgments/settlements, restriction of privileges, etc.; board certification, if applicable professional education, if not board certified; and documentation of after-hours, on-call support providers. NOTE: new Insurance requirements beginning October 1, 2013 include Commercial General Liability, Business Automobile Liability, Worker's Compensation and Employer's Liability and Professional Liability. Contact your Provider Performance Representative for further information and/or refer to the AHCCCS Minimum Subcontract Provisions located on the AHCCCCS website at:
https://www.azahcccs.gov/PlansProviders/NewProviders/minimumsubcontractprovisions.html

All Health Choice Arizona participating providers shall be re-credentialed every 36 months in order to ensure their continued adherence to Health Choice Arizona credentialing and quality standards. Aperture™ (CVO) will make a maximum of up to three attempts over a 60-day period to obtain recredentialing information. Failure by the provider to submit the completed recredentialing application following the third attempt will be considered a voluntary withdrawal of the application and may result in the provider not being retained in the Health Choice Arizona network.

In addition to the elements listed in the initial credentialing procedure and process, the Health Choice Arizona recredentialing process shall also include review of the following data: Review of any quality or risk management issues in addition to an assessment of possible negative trends in the provider's activities; PCPs and primary care obstetrician, physician panel size; comparison of the provider regarding performance measures to their specialty averages, and the plan average; review of any member complaints or grievances; results of any member satisfaction survey or statements; review of appointment availability surveys; review of member PCP change trends; review of general cooperation with Health Choice Arizona staff, policies and procedures and cooperation with other network participants; review of any information forwarded from AHCCCS or CMS regarding large member panels, i.e., more than the AHCCCS or CMS advised maximum. In such cases the QM file on the applicant will be carefully reviewed to ensure that large member panels are not compromising quality of care in any way. Reports from AHCCCS or CMS will be reviewed at the time they are available even if the provider is not due for recredentialing. Approval of the re-credentials is for a 36 month period, or in the presence of any unusual history, approval

for a shorter term or with appropriate limitations, restrictions or supervision may be given. In the event that denial of the recredentialing of the provider occurs, the provider may, if he/she so chooses, appeal the decision through the QM Appeals Process. Within one (1) business day of the Credentialing Committee meeting, the Credentialing Department will notify the Provider Network Department of the Committee's credentialing decision(s). HCMC may designate approval authority to the Chief Medical Officer/Medical Director or/designee to review and approve "clean files" in accordance to the credentialing policies and procedures, and does not need to proceed through the Credentialing Committee. There must be evidence which includes handwritten signature, handwritten initials or electronic identifier of the review and approval on a list of all providers who meet the established criteria.

For "clean files", the Chief Medical Officer/Medical Director or/designee review date will be used as the "credentialing decision date." The Credentialing Coordinator (or designee) will notify Provider Relations staff of the Chief Medical Officer/Medical Director or/designee decision of "clean files" no later than one (1) week of the review date. The Provider Network Department will notify the providers of the committee's decision within 60 days of notification from the Credentialing Coordinator.

5.7 PEER REVIEW

The Peer Review Program is designed to develop, implement and evaluate required peer review activities regarding health care delivery concerns that affect the Health Plan's members and participating practitioners and providers. Member safety and quality medical care are the central goals underlying all peer review activities. Peer review is conducted using evidence-based clinical guidelines, when available, or practice parameters that are nationally recognized. Specific provider concerns as well as more global provider network issues are addressed by Health Choice Arizona through the peer review process.

Any report of a deficiency in the quality of care (QOC) or the omission of care or service by a provider is subject to peer review. Referrals of potential peer review issues may be initiated by external or by any internal Health Choice Arizona department with a potential referral to QM for research and review. Internal sources may include Health Choice Arizona department staff members who identify potential specific peer review quality issues while conducting their daily operations, member or provider appeals, Health Choice Arizona medical committees, provider profiling reports, on-site provider reviews and utilization management reports. Internal potential QOC referrals are sent to the QM department documented on a *grievance/complaint form* with an attachment of any supporting documentation such as utilization reports, excerpts of medical progress notes, or other pertinent documents available. External sources include state and/or federal agencies, media reports, other providers, members, member representatives, advocates and caregivers. Information from external sources may be received by Health Choice Arizona via a letter, phone calls directly to the Chief Medical Officer/Medical Director, or email. If you are interested in participating in the Quality/Peer Review Committee, please call the Director of Quality Management at (602) 829-3355. All committee members must be licensed practitioners and sign confidentiality agreements.

Health Choice Arizona also utilizes peer review processes in contracting and credentialing decisions. The QM/PIC Executive peer review session, which meets as needed throughout the year, is responsible for performing peer review. The Committee investigates upper severity level cases involving Providers that may have an effect on the quality of care provided to members. The Committee consists of the Health Choice Arizona Chief Medical Officer and/or the Medical Director and, at a minimum, the Director of Quality Management, representation from the functional areas within Health Choice Arizona, representation of contracted or affiliated providers serving AHCCCS members, and appropriate clinical representatives. A dentist who works as a consultant for Health Choice Arizona serves on the committee when dental information is required. If additional expertise is required for a specific peer review case, other specialists are brought in on an ad hoc basis. Health Choice Arizona has contracted with an external peer review company to provide expertise that may not be available locally. The QM/PIC Executive peer review session, based upon its investigation, may recommend one or more of the following actions:

- Make a recommendation for corrective action which may include (without limitation) education.
- Request an outside consultation with provider in same specialty (if one is not on the committee) prior to making a recommendation.
- Request additional information.
- Request the provider develops and implements a corrective action plan addressing the specific issues necessary to improve the quality of care provided to Health Choice Arizona members.
- Reduce, restrict, suspend, terminate or not renew the provider's credentials necessary to treat members as a participating provider of Health Choice Arizona.
- Recommend assigning or adjusting a severity rating.
- Other action necessary to evaluate the issue and recommend appropriate adverse or corrective action, such as a Focused Provider Review (FPR).

The QM/PIC Executive peer review session is responsible for reporting quality issues and Health Choice Arizona actions regarding these issues, as required or allowed by law, to the appropriate authorities including but not limited to, the Board of Medical Examiners, Osteopathic Board, Podiatric Board, National Practitioners Data Bank, and the Arizona Medicaid Administration. Under the Chief Medical Officer/Medical Director's direction, agencies will be notified of the QM/PIC Executive peer review session's decision regarding adverse actions.

Results of peer review activities and of the QM/PIC Executive peer review session's recommendations and actions are documented in the providers file. The actions of the QM/PIC are communicated to all appropriate Health Choice Arizona staff to ensure that contracting and credentialing decisions are made timely and with accurate information to ensure the highest quality medical care for members.

The formal peer review process at Health Choice Arizona is accomplished by evaluating the clinical activities and qualifications of practitioners and providers through the efforts of the QM

Department and other review committees of Health Choice Arizona. This process is pursuant to the QM/PI (Performance Improvement) Plan and A.R.S. 36-2401 et seq. and 36-2917 ("Arizona Peer Review Laws"). If an adverse action is taken against a provider as a result of the peer review process, the provider has certain rights pursuant to Health Choice Arizona Policy C.9.023 *Peer_Review_Process_Appeals*, which addresses "Peer Review Process and Appeals." This policy is available upon request from your Provider Performance Representative, and will be sent to any provider when an adverse action is taken. The provider has the right to appeal the following:

- Any adverse action that is disputed by the provider in question may be appealed.
- This option shall be communicated to the provider via a certified letter from the Chief Medical Officer/Medical Director (s). The letter shall state the adverse action and the basis for the finding. The provider may appeal such actions by sending a letter to the Health Choice Arizona Chief Medical Officer/Medical Director (s) requesting invocation of the appeal process.
- If the provider chooses to appeal the adverse action, an ad hoc appeals committee consisting of three (3) providers who are certified to practice in the same specialty. (Policy C.9.023) shall be appointed to serve, in addition to the QM/PIC, to hear the provider's appeal and all evidence presented.
- This committee will review all information and make a formal recommendation regarding the appeal. The details of this process are available and shall be communicated to the provider at the onset of notification of the adverse action.

5.8 MEDICAL RECORD STANDARDS

Providers are required to maintain medical records in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and which facilitates an adequate system for follow-up treatment. The provider must ensure that records are accessible to authorized persons only. Medical records must be available to Health Choice Arizona and AHCCCS for purposes of quality review or other administrative requirements, free of charge to Health Choice Arizona and any vendor Health Choice Arizona delegates to for the purposes of Medical Record Reviews.

A.R.S. 32-1401(2) defines adequate medical records as "legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warning provided to the patient and to provide for another practitioner to assume continuity of the patients care at any point in the course of treatment."

Health Choice Arizona has aligned efforts under the Arizona Association of Health Plans (AzAHP) to conduct Medical Record Review (MRR), similar to the coordinated credentialing process implemented October 1, 2012. AzAHP has engaged AdvantMed as the vendor that will be conducting these reviews on behalf of all participating Arizona Medicaid Health Plans. This collaborative approach will reduce the burden to your office by decreasing the number of parties requesting medical records. This process change stems from the most recent changes within the

Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM), Chapter 900 - Quality Management and Performance Improvement Program related to on-going monitoring of medical records for contracted Pediatricians, Primary Care Physicians (PCPs), and Obstetrician/Gynecologists (OB/GYNs).

The medical record/chart review will consist of, but will not be limited to, reviewing compliance related to the following areas:

- General Medical Record Documentation
- Medical/Social History/Medical Management
- Health Maintenance (Laboratory/Diagnostic Studies)
- Behavioral Health
- Family Planning
- Perinatal and Postpartum Depression Screenings

Medical record reviews are required every three years. **When your review is due, AdvantMed will be contacting you** to request your assistance in securing the medical records necessary to complete this review. Based on existing contracts with the Health Plans, you are required to provide a copy of medical records within the timeframes and at no charge. It is important that you work collaboratively with AdvantMed in providing the requested records when contacted to avoid jeopardizing your status with one or more of the Health Plans.

Should you use a vendor that provides copies of your medical records, such as HealthPort, please provide notification to them of your requirement to provide records to AdvantMed on behalf of the health plans, at no cost.

Please advise them of the following AHCCCS requirement and Arizona Administrative Code:

> *AHCCCS contracted providers are required to furnish copies of medical records to an AHCCCS contractor free of charge. According to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rules (CFR 164) health care providers are permitted to disclose protected health information for the purposes of treatment, payment and/or healthcare operations without authorization from the member. Health plans receive these records for official purposes directly related to its operations as an AHCCCS contractor.*
>
> *Federal and State Legal Reference:*
> ***AHCCCS states: under Arizona Administrative Code R9-22-512 (E)***
> *A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.*

All information in the medical record and information received from other providers must be kept confidential. Per AHCCCS requirements, when a member changes PCPs, his or her medical records or copies of the medical records must be forwarded to the new PCP within 10 working days of receipt of a properly executed request for the medical records.

Health Choice Arizona supports the AHCCCS, URAC, and NCQA medical record standards. These are the minimum standards acceptable for medical record documentation within Health Choice Arizona's contracted network of primary care physicians, primary care obstetricians and high volume specialists.

Primary Care Providers (PCPs) must maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member.

PCPs are further required to ensure the medical record documents provider referrals to other providers, coordination of care with other providers, and transfer of care to behavioral health providers, as appropriate, make certain the medical record is legible, kept up-to-date, well-organized and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member.

Health education, preventive services recommendations and wellness counseling should be clearly noted and incorporated in the progress notes or in a designated section of the medical records. These services should be documented as applicable:

- Annual Well Visit
- Date of last cervical cancer screening
- Date of mammogram screening
- Prostate screening
- Alcohol, smoking, or substance abuse assessment and treatment recommendations
- Exercise recommendation
- Nutritional status body mass index (BMI) and weight deviations from normal
- Immunizations
- Family planning counseling
- Children Dental Visit
- Colorectal Cancer Screening
- Diabetic Eye Exam
- Diabetic Blood Sugar Control
- Diabetic Monitoring for Nephropathy
- Medication Adherence
- When to use the ED or urgent care Medication Review (Reconciliation)
- Osteoporosis Management in Women with Prior Fractures

PCPs must maintain a comprehensive record that incorporates at least the following components:

- Behavioral health information when received from the behavioral health provider about

an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

- Member identification information on each page of the medical record (i.e.name or AHCCCS identification number).
- Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
- Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member).
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received.
- Immunization records (required for children; recommended for adult members if available.
- Dental history, if available, and current dental needs and/or services.
- Current problem list
- Current medications
- Current and complete EPSDT forms (required for all members age 0 through 20 years).
- Documentation, initialed by the member's provider , to signify review of:
    - Diagnostic information including:
    - Laboratory tests and screenings,
    - Radiology reports,
    - Physical examinations notes, and
    - Other pertinent data
    - Reports from referrals, consultations and specialists,
    - Emergency/urgent care reports.
    - Hospital discharge summaries,
    - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed.
- Behavioral health history and information.
- Documentation as to whether or not an adult member has completed advance directives and location of the document.
- Documentation that the provider responds to behavioral health provider information request within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.

- Documentation related to requests for release of information and subsequent releases.
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- Obstetric providers must complete a standardized, evidence –based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologist [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.
- Ensure that PCPs utilize AHCCCS approved developmental screening tools.
- Organization provider services (e.g. hospitals, nursing facilities, rehabilitation clinics, transportation etc.) maintain a record of services provided to the member including:
    - Physician or provider orders for the service,
    - Applicable diagnostic or evaluation documentation,
    - A plan of treatment,
    - Periodic summary of the member's progress toward treatment goals,
    - The date and description of service modalities provided, and
    - Signature/initials of the provider for each service
- Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
- Must have an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified.
- Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or professionals provide services.

Medical records may be documented on paper or in an electronic format.

- If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date of each entry.
- If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape is not allowed.
- If kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.
- If revisions to information are made, a system must be in place to track when, and by whom they are made. In addition, a back-up system including initial and revised information must be maintained. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified.

- Documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.

The member:

- May review, request, and annually receive a copy, free of charge, of those portions of the DRS that were generated by the provider
- May request that specific provider information is amended or corrected, and
- May not review, request, amend, correct or receive a copy of the portions of the DRS that are prohibited from view under the Health Insurance Portability and Accountability Act (HIPAA)

AHCCCS and Health Choice Arizona are not required to obtain written approval from a member before requesting the member's DRS from a healthcare provider or any agency. For purposes relating to treatment, payment or health care operations, AHCCCS and Health Choice Arizona may request sufficient copies of records necessary for administrative purposes, free of charge.

Written approval from the member is not required by the Primary Care Provider (PCP) when:

- Transmitting member records to a provider when services are rendered to the member through referral to a Contractor's subcontracted provider,
- Sharing treatment or diagnostic information with the member's Integrated Regional Behavioral Health Authority (Integrated RBHA) or Regional Behavioral Health Authority (RBHA) acting as a provider, or its contracted providers, if the member is receiving behavioral health services through the Integrated RBHA/RBHA system, or
- Sharing medical records with the member's health plans.

Information related to fraud and abuse against the AHCCCS program may be released to authorized officials in compliance with Federal and State statutes and rules.

ALL ORGANIZATIONAL PROVIDER OF SERVICES
For example, hospitals, nursing facilities, rehabilitation clinics, transportation, etc. all maintain a record of the services provided to a member, including:

- Physician or provider orders for the service,
- Applicable diagnostic or evaluation documentation,
- A plan of treatment,
- Periodic summary of the member's progress toward treatment goals,
- The date and description of service modalities provided, and
- Signature/initials of the provider for each service.
- Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

TRANSPORTATION SERVICES DOCUMENTATION

- For providers that supply transportation services for recipients using provider employees (i.e. facility vans, drivers, etc.) the following documentation requirements apply:
    - Complete service provider's name and address;
    - Signature and credentials of the driver who provided the service;
    - Vehicle identification (car, van, wheelchair van, etc.);
    - Members' Arizona Health Care Cost Containment System (AHCCCS) identification number;
    - Date of service, including month day and year;
    - Address of pick up site;
    - Address of drop off destination;
    - Odometer reading at pick up;
    - Odometer reading at drop off;
    - Type of trip – round trip or one way;
    - Escort (if any) must be identified by name and relationship to the member being transported; and
    - Signature of the member, parent and/or guardian/caregiver, verifying services were rendered. If the member refuses to sign the trip validation form, then the driver should document his/her refusal to sign in the comprehensive medical record.
- For providers that use contracted transportation services, for non-emergency transport of recipients, that are not direct employees of the provider (i.e. cab companies, shuttle services, etc.) see Policy 201, Covered Services for a list of elements recommended for documenting non-emergency transportation services.
- It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.

DISCLOSURE OF RECORDS

All medical records, data and information obtained, created or collected by the provider related to member, including confidential information must be made available electronically to Health Choice Arizona, AHCCCS or any government agency upon request.

When a recipient changes his or her PCP, the provider must forward the member's medical record or copies of it to the new PCP within ten (10) business days from receipt of the request for transfer of the record.

Behavioral health records must be maintained as confidential and must only be disclosed according to the following provisions:

- When requested by a member's primary care provider (PCP) or the member's Department of Economic Security/Division of Developmental Disabilities/Arizona Long-Term Care System (DES/DDD/ALTCS) support coordinator, the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days

of the request

- Health Choice Arizona and subcontracted providers must provide each member who makes a request one copy of his or her medical record free of charge annually.
- Health Choice Arizona and subcontracted providers must allow, upon request, recipients to view and amend their medical record as specified in **45 C.F.R. § 164.524**, **164.526** and **A.R.S. § 12-2293**.

Behavioral health records must contain the following elements:

- Intake paperwork documentation that includes:
  - For members receiving substance abuse treatment services under the Substance Abuse Block Grant (SABG), documentation that notice was provided regarding the recipient's right to receive services from a provider to whose religious character the recipient does not object;
  - Documentation of recipient's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
  - Contact information for the member's PCP if applicable.
- Assessment documentation that includes:
  - Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information
  - Diagnostic information including psychiatric, psychological and medical evaluations;
  - Copies of Notification of Persons in Need of Special Assistance
  - An English version of the assessment and/or service plan if the documents are completed in any other language other than English; and
  - For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.
- Treatment and service plans documentation that includes:
  - The recipient's treatment and service plan;
  - Child and Family Team (CFT) documentation;
  - Adult Recovery Team (ART) documentation; and
  - Progress reports or service plans from all other additional service providers.

- Progress notes documentation that includes:
  - Documentation of the type of services provided;
  - The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a primary diagnosis is identified, the person may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable;
- The date the service was delivered;
  - Duration of the service (time increments) including the code used for billing the

service;
    - A description of what occurred during the provision of the service related to the recipient's treatment plan;
    - In the event that more than one provider simultaneously provides the same service to a recipient, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
    - The recipient's response to service; and
    - For recipients receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.
- Medical services documentation that includes:
    - Laboratory, x-ray, and other findings related to the member's physical and behavioral health care;
    - The member's treatment plan related to medical services;
    - Physician orders;
    - Requests for service authorizations;
    - Documentation of facility-based or inpatient care;
    - Documentation of preventative care services;
    - Medication record, when applicable;
    - Documentation of psychotropic and antipsychotic medication assessment by the Behavioral Health Medical Professional prior to prescribing or providing the medication; and
    - Documentation of Certification of Need (CON) and Re-Certification of Need (RON when applicable.
- Reports from other agencies that include:
    - Reports from providers of services, consultations, and specialists;
    - Emergency/urgent care reports; and
    - Hospital discharge summaries.
- Paper or electronic correspondence that includes:
    - Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management of the recipient's health care;
    - Documentation of any requests for and forwarding of behavioral health record information.
- Financial documentation that includes:
    - Documentation of the results of a completed Title XIX/XXI screening
    - Information regarding establishment of any copayments assessed, if applicable.
- Legal documentation including;
    - Documentation related to requests for release of information and subsequent releases
    - Copies of any advance directives or mental health care power of attorney as defined the Advance Directives section of this Chapter, including:
        - Documentation that the adult person was provided the information on advance directives and whether an advance directive was executed

- Documentation of authorization of any health care power of attorney that appoints a designated person to make health care decisions (not including mental health) on behalf of the person if they are found to be incapable of making these decisions;
- Documentation of authorization of any mental health care power of attorney that appoints a designated person to make behavioral health care decisions on behalf of the person if they are found to be incapable of making these decisions. Documentation of general and informed consent to treatment
- Any extension granted for the processing of an appeal must be documented in the case file, including the Notice regarding the extension sent to the recipient and his/her legal guardian or authorized representative, if applicable.

Providers who are making a referral must transmit necessary information to the provider receiving the referral.

- A provider furnishing a referral service reports appropriate information to the referring provider.
- Providers request information from other treating providers as necessary to provide appropriate and timely care.
- Information about services provided to a member by a non-network provider (i.e., emergency services, etc.) is transmitted to the member's Primary Care Provider (PCP).
- Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.
- The service plan must be sent to all of the non-behavioral health home service providers on the plan within 7 days of completion. For additional assistance with receiving a copy of the service plan, please contact Member Services.

Providers must retain the original or copies of member medical records as follows:

- For an adult, for at least six (6) years after the last date the adult member received medical or health care services from the provider; or
- For a child, either for at least three (3) years after the child's eighteenth birthday or for at least six (6) years after the last date the adult member received medical or health care services from the provider, whichever occurs later.

The maintenance and access to the member medical record shall survive the termination of a Provider's contract with Health Choice Arizona, regardless of the cause of the termination. Federal and state law allows for the transfer of behavioral health medical records from one provider to another, without obtaining the member's written authorization if it is for treatment purposes (**45 C.F.R. § 164.502(b)**, **164.514(d)** and **A.R.S. 12-2294(C)**). Generally, the only instance in which a provider must obtain written authorization is for the transfer of alcohol/drug and/or communicable disease treatment information.

The original provider must send that portion of the medical record that is necessary to the continuing treatment of the behavioral health recipient.

In most cases, this includes all communication that is recorded in any form or medium and that relate to patient examination, evaluation or behavioral health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to section **A.R.S. § 36-441**, **36-445**, **36-2402** and **36-2917**.

REQUIREMENTS FOR COMMUNITY SERVICE AGENCIES (CSA), HOME CARE TRAINING TO HOME CARE CLIENT (HCTC) PROVIDERS AND HABILITATION PROVIDERS

Health Choice Arizona requires that CSA, HCTC Provider and Habilitation Provider clinical records to the following standards. Each record entry must be:

- Dated and signed with credentials noted;
- Legible text, written in blue or black ink or typewritten; and
- Factual and correct.

If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.

CSAs, HCTC Providers and Habilitation Providers must maintain a record of the services delivered to each behavioral health recipient. The minimum written requirement for each behavioral health recipient's record must include:

- The service provided (including the code used for billing the service) and the time increment;
- Signature and the date the service was provided;
- The name title and credentials of the person providing the service;
- The recipient's CIS identification number and AHCCCS identification number;
- Health Choice Arizona conducts routine audits to ensure that services provided by the agency/provider are reflected in the behavioral health recipient's service plan. CSAs, HCTC Providers and Habilitation Providers must keep a copy of each behavioral health recipient's service plan in the recipient's record; and
- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

Every thirty (30) days, a summary of the information required in this chapter must be transmitted from the CSA, HCTC Provider or Habilitation Provider to the recipient's clinical team for inclusion in the comprehensive clinical record.

5.9 ADVANCE DIRECTIVES

As per AHCCCS Policy 640 Advance Directives and AHCCCS Policy 930 Member Rights and Responsibilities, hospitals, nursing facilities, hospice providers, and providers of home health care or personal care services must comply with Federal and State laws regarding advance directives for adult members [42 U.S.C. § 1396(a)(57)]. Providers must discuss advance directives

with all adult members receiving medical care. Adult members and members with special healthcare needs or their representatives are provided written information about formulating advance directives that ensures involvement with the healthcare practitioner.

For members in a Behavioral Health Residential Setting (BHRF) that have completed an Advance Directive, the document must be kept confidential but be readily available (for example: in a sealed envelope attached to the refrigerator). The Arizona Secretary of State maintains a free registry called the "Arizona Advance Directive" where individuals can send advance directives for secure storage which can be accessible to individuals, loved ones and health care providers. This webpage also has other resources available on advanced directives. If changes occur in State law regarding advance directives, adult persons receiving behavioral health services must be notified by their provider regarding the changes as soon as possible, but no later than 90 days after the effective date of the change.

5.10 HEALTH CARE-ACQUIRED CONDITIONS AND PROVIDER-PREVENTABLE CONDITIONS

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable conditions. Provider Preventable Condition means a condition that meets the definition of a Health Care Acquired Condition (HCAC) or an Other Provider Preventable Condition (OPPC). If an HCAC or OPPC is identified, Health Choice Arizona Quality Management will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit. All HCACs or OPPCs must be reported to Health Choice Arizona Quality Management.

Health Care-Acquired Conditions (HCAC) means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient hospital setting and is not present on admission and include:

- Foreign Object Retained after Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
    - Fractures
    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burns
    - Electric Shock
    - Other Injuries
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma

    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following Coronary Artery Bypass Graft (CABG) - Mediastinitis
- Surgical Site Infection Following Bariatric Surgery for Obesity
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

Other Provider-Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

- Surgical or other invasive procedure performed on the wrong patient
- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part or site