ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Division of Fee-for-Service Management (DFSM) Provider Education

Quality of Care Overview

October 27, 2026

DFSM Quality of Care Overview Facilitators



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Quality Administrator



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Quality Assurance Manager

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM



Arizona Health Care Cost Containment Services Commitment

Mission: Reaching across Arizona to provide comprehensive, quality health care to those in need.

Vision: Shaping tomorrow's managed care...from today's experience, quality and innovation.

Values: Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership, and Courage

Credo: Our first care is your health care.

Division of Fee-for-Service Management (DFSM)

While the majority of the AHCCCS populations are managed under a Managed Care Organization (MCO), approximately 12% of AHCCCS membership is under FFS management. The DFSM is responsible for the clinical, administrative, and claims functions of the FFS population of more than 280,000 members. This includes:

- American Indian/Alaska Natives (AI/AN) enrolled in the American Indian Health Program (AIHP) for integrated acute physical and behavioral health services,
- Members enrolled with the Tribal Regional Behavioral Health Authorities (TRBHAs) for behavioral health care coordination services,
- Members enrolled with the Tribal Arizona Long Term Care System programs (Tribal ALTCS),
- Individuals in the Federal Emergency Service (FES) program.

DFSM Quality Administration

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AHCCCS DFSM Quality Administration

The DFSM Quality Management team is responsible for investigating quality of care (QOC) concerns for fee-for-service members.

The DFSM Quality Assurance team is responsible for working with providers on any corrections needed to enhance and improve quality of care.



Quality Management

- The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services; can be assessed at a member, provider, or population level.

- Quality management in healthcare ensures patient safety, improves outcomes, and increases efficiency by reducing errors, streamlining processes, and promoting continuous improvement, ultimately leading to better care and patient satisfaction.



AHCCCS Provider Participation Agreement (PPA)

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Provider Participation Agreement (PPA)

The AHCCCS Provider Participation Agreement (PPA) provides the authority for AHCCCS/DFSM to ensure that FFS providers comply with all applicable State and Federal rules and regulations, including alignment with State licensure requirements, as well as AHCCCS rules and policies relating to the audit of provider records and the inspection of the provider's facilities.

FFS providers are responsible for adhering to the requirements specified in all applicable AHCCCS policies.

- Provider Participation Agreement (PEP-202.8)
- Group Biller Provider Participation Agreement (PEP-202.9)

Provider Participation Agreement Requirements

- Per the PPA, all AHCCCS registered providers are required to serve FFS Members (i.e. AIHP, TRBHA, Tribal ALTCS). Providers shall not steer members to change their health plan. All health plan decisions are at the sole discretion of the member and according to their voice and choice and not the provider's health plan preference. Steering members to make changes to their health plan may constitute a violation of the PPA and grounds for termination of AHCCCS provider status.

Reporting Changes in AHCCCS Provider Enrollment Portal (APEP)

- AHCCCS Provider Enrollment Portal
- Per AMPM 610: Providers are required to report changes to hours of operation, service address, ownership changes and closures within 30 calendar days prior to the effective date change.
- In case of an emergency that results in a temporary facility closure, a provider shall provide AHCCCS written notice within five business days of the emergency.
    - The closure and the reason for closure must be posted at the entrance of the facilities.
- Providers shall report Behavioral Health Professional (BHP) changes within 30 calendar days, as applicable.

State Agency Interactions

- Providers may interact with multiple State agencies such as;
  - AHCCCS: Arizona Health Care Cost Containment System
  - ADHS: Arizona Department of Health Services
  - APS/ DCS: Adult Protective Services / Department of Child Safety
- Within AHCCCS, providers may interact with multiple divisions such as;
  - DMPS: Division of Member and Provider Services
  - DFSM: Division of Fee-for-Service Management
  - OIG: Office of Inspector General
  - DMC: Division of Managed Care
- Providers are responsible for knowing and following other agency rules, regulations and procedures for applicable reporting requirements, separate from AHCCCS.

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AHCCCS Medical Policy Manual (AMPM)

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AHCCCS Medical Policy Manual

- The AHCCCS Medical Policy Manual provides essential guidance to contractors, subcontractors, and providers on services under the AHCCCS Program.
- It aligns with federal and state regulations, agency guidelines, and applicable contracts.
- AMPM applies to Managed Care Organization (MCO) Contractors, their delegated subcontractors, and Fee-For-Service (FFS) Programs including:
    - American Indian Health Program (AIHP),
    - Tribal Regional Behavioral Health Authorities (TRBHA),
    - Tribal Arizona Long Term Care Services (Tribal ALTCS),
    - Federal Emergency Services Program (FES/FESP)
    - DDD-Tribal Health Program (DDD-THP)
- *Additional guidance to the TRBHAs and Tribal ALTCS are also in their IGAs

AMPM Policy 961 Incident, Accident and Death Reporting

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Quality of Care Concerns (QOC)

An allegation that any aspect of care, treatment, or utilization of behavioral or physical health services may have caused or could cause an acute or chronic medical or psychiatric condition, potentially leading to harm for an AHCCCS member.



Incident, Accident, Death Reporting (IAD)



Reporting IADs to the AHCCCS QM portal is critical because it ensures timely identification and resolution of issues that may affect member safety or quality of care.

- It helps maintain compliance with AHCCCS requirements,
- Facilitates tracking of trends and patterns,
- Enables the implementation of corrective actions to prevent recurrence,
- Supports accountability and transparency,
- Helps protect both members and healthcare providers while improving overall healthcare delivery and outcomes.

AMPM Policy 961: Reporting IADs and Quality of Care Concerns

AMPM Policy 961 Incidents, Accidents and Death Reporting

This policy outlines FFS programs and providers' responsibilities for reporting Quality of Care (QOC) concerns, incidents, accidents, deaths (IAD), and health and safety conditions. It includes compliance with state licensure requirements, on-site inspections, documentation requests, and provider responsibilities during member transitions.



AMPM 961 Reportable IADs



An IAD is reportable if it includes any of the following:

a. Allegations of abuse, neglect, or exploitation of a member,

b. Death of a member,

c. Delays or difficulties in accessing care (e.g., outside of the timeline specified in ACOM Policy 417),

d. Healthcare acquired conditions and other provider preventable conditions (refer to AMPM Policy 960 and AMPM Policy 1020),

e. Serious injury,

f. Injury resulting from the use of a personal, physical, chemical, or mechanical restraint or seclusion (refer to AMPM Policy 962),

AMPM 961 Reportable IADs

g. Medication error occurring at a licensed Provider site including:

i. Behavioral Health Residential Facility (BHRF),

ii DDD Group Home,

iii. DDD Adult Developmental Home,

iv. DDD Child Developmental,

v. Assisted Living Facility (ALF),

vi. Skilled Nursing Facility (SNF),



vii. Adult Behavioral Health Therapeutic Home (ABHTH)

viii. Therapeutic Foster Care Home (TFC), and any other alternative Home and Community Based Service (HCBS) setting as specified in AMPM Policy 1230-A and AMPM Policy 1240-B,

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AMPM 961 Reportable IADs

h. Missing person from a licensed Behavioral Health Inpatient Facility (BHIF), BHRF, DDD Group Home, ALF, SNF, ABHTH, or TFC,

i. Member suicide attempt,

j. Suspected or alleged criminal activity, and

k. Any other incident that causes harm or has the potential to cause harm to a member.



AMPM Policy 961 Sentinel Incidents, Accidents, Deaths

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What Is A Sentinel IAD?

A "sentinel event" is a serious, unexpected occurrence in a healthcare setting that results in a patient's death, severe harm, or permanent harm, signaling the need for immediate investigation and response to prevent similar events from happening again.



Sentinel IADs

Sentinel IADs shall be submitted by the provider into the AHCCCS QM Portal within 24 hours of the occurrence or within 24 hours of becoming aware of the occurrence.



Sentinel IADs

a. Member death or serious injury associated with a missing person,

b. Member suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting,

c. Member death or serious injury associated with a medication error,

d. Member death or serious injury associated with a fall while being cared for in a healthcare setting,

e. Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or upon presentation to a healthcare setting,

f. Member death or serious injury associated with the use of seclusion and/or restraint while being cared for in a healthcare setting,

g. Sexual abuse/assault on a member during the provision of services regardless of the perpetrator,

h. Death or serious injury of a member resulting from a physical assault that occurs during the provision of services, and

i. Homicide committed by or allegedly committed by a member.

AHCCCS Quality Management Portal

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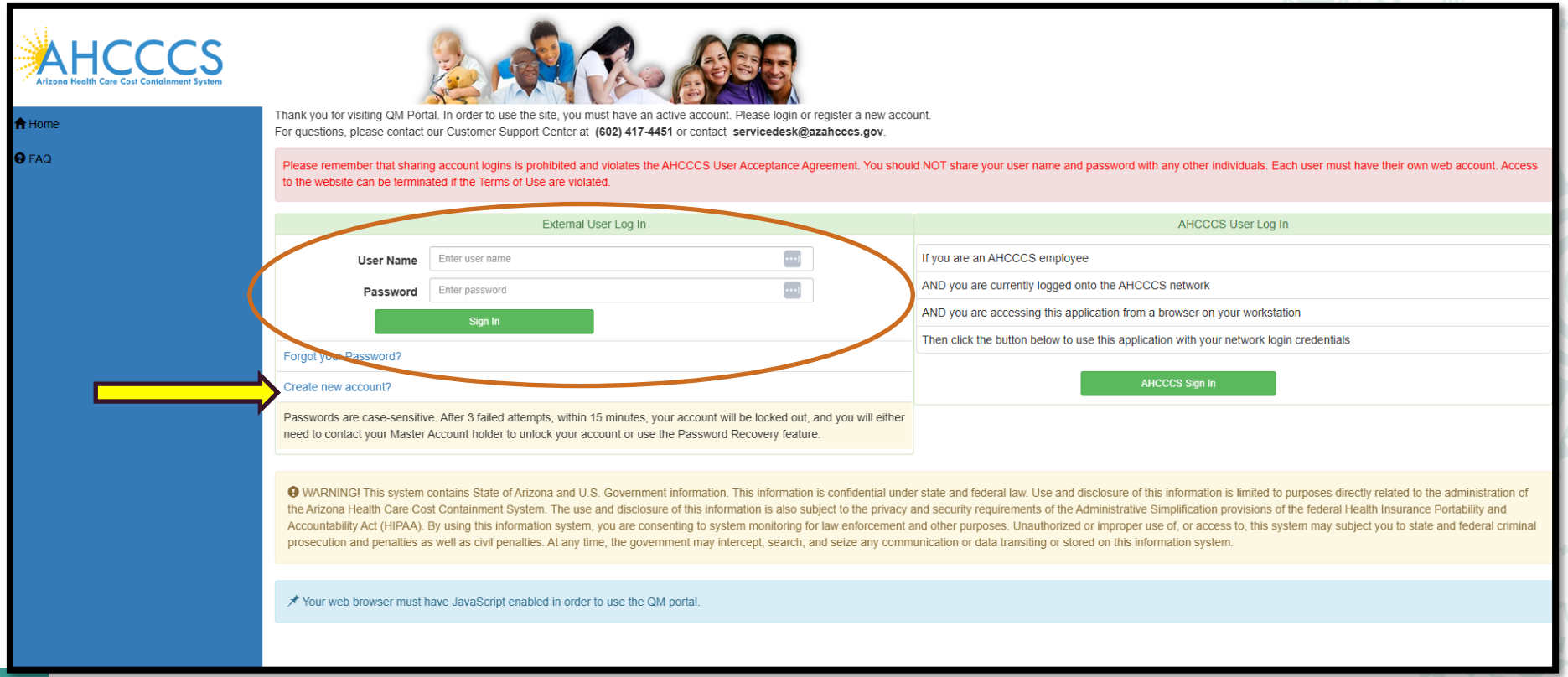
Quality Management (QM) Portal

- Per the PPA, providers must be registered in the AHCCCS Quality Management Portal within 30 days of becoming active
  - QM Portal: https://qmportal.azahcccs.gov/
  - Providers are responsible for keeping their portal logins current
    - Login at least once **every 30 days** to stay in active status
      - A deactivated status will require the provider to re-register

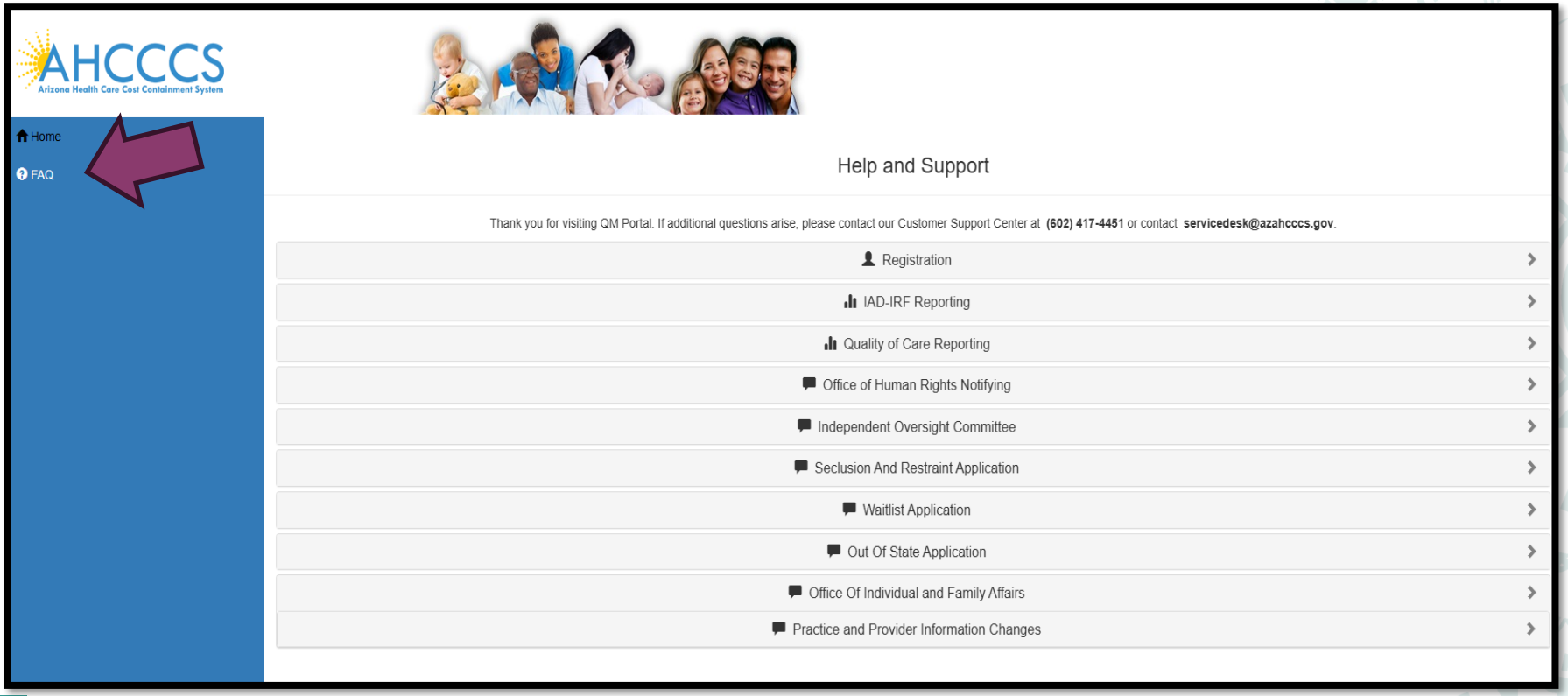
QM Portal

- Providers are encouraged to add additional users to their administrator master account
    - Providers are responsible for reviewing the QM Portal and any new cases, messages or feedback for the disposition of cases
    - Providers shall not share passwords; every user must have their own login
- Non-compliance with these reporting requirements shall be considered a violation of the PPA
- For technical issues or customer support:
    - Please contact our Customer Support Center at (602) 417-4451 or enter a ticket via the AHCCCS Solutions Center.

QM Portal

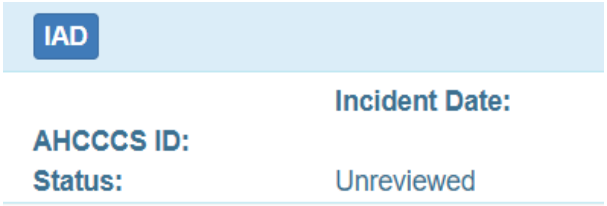

AHCCCS
Arizona Health Care Cost Containment System
Home
FAQ
Thank you for visiting QM Portal. In order to use the site, you must have an active account. Please login or register a new account.
For questions, please contact our Customer Support Center at (602) 417-4451 or contact servicedesk@azahcccs.gov.
Please remember that sharing account logins is prohibited and violates the AHCCCS User Acceptance Agreement. You should NOT share your user name and password with any other individuals. Each user must have their own web account. Access to the website can be terminated if the Terms of Use are violated.
External User Log In
User Name
Enter user name
Password
Enter password
Sign In
Forgot your Password?
Create new account?
Passwords are case-sensitive. After 3 failed attempts, within 15 minutes, your account will be locked out, and you will either need to contact your Master Account holder to unlock your account or use the Password Recovery feature.
AHCCCS User Log In
If you are an AHCCCS employee
AND you are currently logged onto the AHCCCS network
AND you are accessing this application from a browser on your workstation
Then click the button below to use this application with your network login credentials
AHCCCS Sign In
WARNING! This system contains State of Arizona and U.S. Government information. This information is confidential under state and federal law. Use and disclosure of this information is limited to purposes directly related to the administration of the Arizona Health Care Cost Containment System. The use and disclosure of this information is also subject to the privacy and security requirements of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). By using this information system, you are consenting to system monitoring for law enforcement and other purposes. Unauthorized or improper use of, or access to, this system may subject you to state and federal criminal prosecution and penalties as well as civil penalties. At any time, the government may intercept, search, and seize any communication or data transiting or stored on this information system.
Your web browser must have JavaScript enabled in order to use the QM portal.

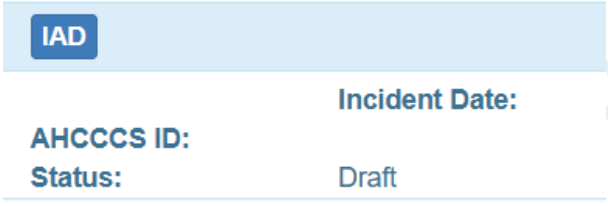
QM Portal FAQ/Help & Support



Tips for a Smooth QM Portal Submission

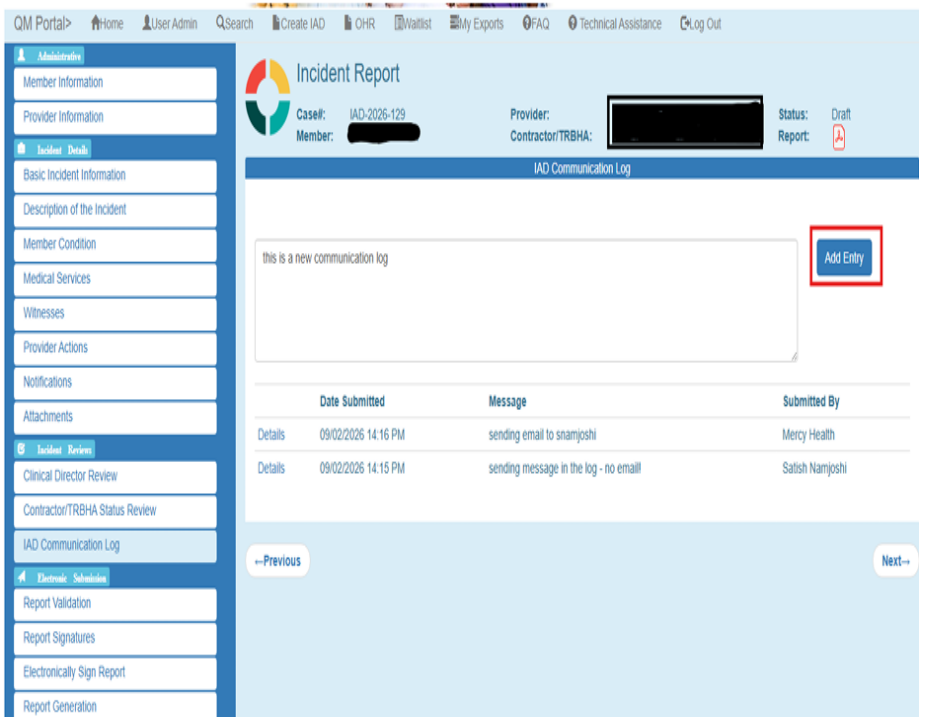
- When submitting a case in the QM portal, confirm the status shows "**Unreviewed**."
- A status of "**Draft**" means the case has not been submitted.
- The QM portal will time out after periods of inactivity. To avoid this, submit cases when all required information is available and distractions are minimal.
- Some providers find it helpful to draft the incident description in a Word document and then copy and paste it into the QM portal to prevent losing work.
- Be sure to check for **draft** cases and resolve any errors, duplicates or finalize any incomplete IADs.





QM Portal Submissions and Communication

- There is now an IAD Communication Log incorporated within the QM portal.
  - Providers can send a message to the health plan via this log.
  - Please be sure to check and respond to any communication requests.
- Please be sure to review closed cases
  - Closed with recommendations



AMPM Policy 830 Quality of Care and Fee-for-Service Provider Requirements

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AHCCCS Medical Policy Manual (AMPM)

AMPM 830 – Quality of Care and Fee-for-Service Provider Requirements

This Policy establishes requirements for FFS Programs and FFS providers regarding reporting of Quality of Care (QOC) Concerns, Incident, Accident, Death (IAD) reports, and Health and Safety conditions, including requirements for FFS providers to comply with state licensure requirements, on-site inspections, and/or requests for information, including documentation; and establishes requirements regarding FFS provider responsibilities during member transitions.

AMPM 830

FFS providers are required to report any Quality of Care (QOC) Concerns and Incidents, Accidents, and Deaths (IADs) as soon as they are aware, and no later than 2 business days after discovering the issue. Reports should be submitted through the QM portal.



AHCCCS DFSM Quality Management(QM) IAD/QOC Review

- All IADs are reviewed, but not all IADs become Quality of Care (QOC) concerns
- Member-specific QOCs should be entered into the QM Portal with as much information as available, including:
  - A detailed incident report describing actions taken by the provider
  - Updated assessments
  - Updated treatment plans (if applicable)
- QM will conduct a clinical quality review of records
  - An on-site visit may be required
- For TRBHA and Tribal ALTCS enrolled members, the TRBHA/Tribal ALTCS may investigate the case
- Providers must maintain a current and accurate census of all members receiving services

AHCCCS DFSM Quality Management
IAD/QOC Systemic Review

Systemic concerns or non-member-specific issues are also reviewed by AHCCCS DFSM.

- Systemic concerns may include:
  - A comprehensive clinical quality review of records conducted:
    - Virtually and/or
    - On-site



Maintain Current Information

- Providers are required to maintain accurate and current correspondence and site contact information in APEP
- This includes updates to phone numbers, email addresses, and key site contacts as changes occur.
- Up-to-date APEP information ensures Quality Management can quickly reach the correct staff for time-sensitive outreach, audits, and investigations
- Inaccurate or outdated contact information may result in delays in communication, missed requests, and potential compliance risk



Health and Safety Situations

- The Providers shall make every effort to resolve a health and safety condition with minimal exposure of the FFS member to the adverse situation or environment
- The Providers retain responsibility for:
- Member safety,
- Care coordination,
- Safe discharge,
- and/or transition of care, and
- Shall work with AHCCCS DFSM QM and TRBHAs and/or Tribal ALTCS Programs to ensure that if warranted, FFS members are re-located to a safe environment

Health and Safety- Prior Authorization (PA) Hold

- In severe health and safety or immediate jeopardy situations, a PA Hold may be implemented while the QOC investigation is under review
- A PA Hold is an administrative action to temporarily restrict the approval of PAs for a provider when there are identified concerns related to member health and safety
- PA Holds may occur for:
    - New admissions only or,
    - New and Concurrent prior authorizations
- The hold, remains in effect pending further review, investigation, or resolution of the identified concerns
- Providers are notified in writing when a PA Hold is in place, and when the decision has been reversed and authorizations may continue

Severity Levels of IADs, IRFs & QOCs

- The severity levels are defined as follows:
- Level 0: (Track and Trend Only)- No Quality issue finding.
- Level 1: A minor quality issue is present, but it is unlikely to cause harm.
- Level 2: A quality issue is present and could cause harm if not addressed timely.
- Level 3: A quality issue that has resulted in harm to a member or recipient and/or presents a serious and ongoing risk to others.
- Level 4: A quality issue exists with the most severe adverse effects on the member or recipient; no longer impacts the member or recipient with the potential to cause harm to others.

On-Site Visits: What to Expect

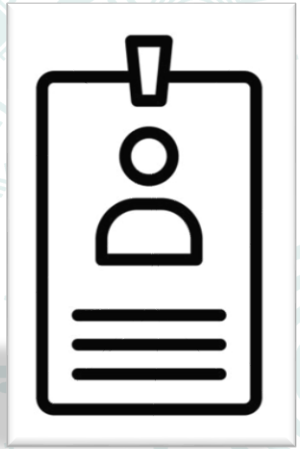
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On-site Visits

- AHCCCS DFSM completes on-site visits as part of their quality-of-care investigation and to check on member health and safety
- Visits are typically unscheduled
- Occur during provider's reported business hours, unless an urgent situation (such as Immediate Jeopardy)
    - Make sure your service location, hours, contact information, ownership or managing employees etc. is updated in AHCCCS Provider Enrollment Portal (APEP)



On-site Visits



- Official state business
  - State vehicle
  - AHCCCS agency name badge (with name of on-site personnel)
  - DFSM Quality Team Business card
  - Official AHCCCS Letterhead request of records
    - Records provided within 2 hours
  - Interview Members
  - Interview Clinical or Medical Director, BHP, BHMP, or other facility staff

Behavioral Health Professionals (BHP) Clinical Oversight and Supervision Requirements

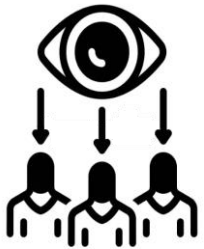
AMPM 310-B & AMPM 610 Title XIX/XXI Behavioral Health Service Benefit

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BHP Clinical Oversight and Supervision

Certain AHCCCS provider types, as required by licensure, are subject to clinical oversight and supervision requirements from a BHP to a BHT or BHPP.

- AMPM policy 310-B specifies the responsibilities of the BHP for directing and overseeing the clinical care and treatment for members they are directly treating, and the services and support provided by Behavioral Health Technicians (BHTs) and Behavioral Health Paraprofessionals (BHPPs) for whom the BHP is providing supervision or clinical oversight. Refer to AAC R9-10 et seq. for specific requirements regarding oversight and supervision.



BHP Requirements: AMPM 610

Per AMPM 610 (A) AHCCCS Registration and Enrollment Requirements, AHCCCS registration is mandatory for consideration of payment by the Contractor for services rendered by managed care providers, submission of encounter data to the AHCCCS Administration, and for FFS Providers rendering services.

- (1) All providers of AHCCCS-covered services, for both managed care and FFS shall:
    - (a) Enroll with AHCCCS, which includes but is not limited to, signing and submitting to AHCCCS a Participation Agreement as applicable.

BHP Requirements: AMPM 610

- Per AMPM 610 (A)(2):
- All Integrated Clinics, Behavioral Health Residential Facilities (BHRFs), and Behavioral Health Outpatient Clinics shall disclose the name, home address, DOB, SSN, credentials, AHCCCS provider ID, and start date of all Behavioral Health Professionals (BHPs).
- This information shall be disclosed upon submission of the enrollment application, upon execution of the participation agreement, and within 30 calendar days of any change in behavioral health professional (BHP) personnel.
- Changes to BHP must be reported in APEP according to policy
- Providers must disclose adverse actions to AHCCCS

Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Referring, Ordering, Prescribing, and Attending (ROPA) Providers

Under the Patient Protection and Affordable Care Act (ACA) and the 21st Century Curess Act (Cures), all ROPA providers must be registered with AHCCCS to ensure compliance with federal regulations.

- ROA launched August 1, 2025, for Referring, Ordering and Attending providers and did not include Prescribers.
- ROPA is launching September 1, 2026, and will now include Prescribers in the registration process
- Fee for Service claims involving unregistered ROPA providers, including Prescribers will be denied.
- Registered ROPA Providers: Must enroll via the AHCCCS Provider Enrollment Portal (APEP)
- AHCCCS offers a simplified process for ROPA-only providers (Providers Type OR)
- Exception Providers: Certain roles like residents, and interns that are not required to register but must be listed on the ROPA Exception Provider List
- Facilities must proactively contact ROPA providers they work with and ensure they are AHCCCS registered.

AMPM 940- Medical Records and Communication of Clinical Information

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Medical Records And Communication Of Clinical Information

- All AHCCCS registered providers are required to maintain comprehensive documentation related to care and services provided to members.
- Providers shall ensure via regular monitoring activities that documentation completed and maintained meets the requirements specified in AMPM 940.



Medical Records And Communication Of Clinical Information



Personal health records



Telemedicine

- Records shall be kept up to date, well organized and comprehensive, with sufficient detail to demonstrate and promote effective member care and ease of quality review. Medical record requirements are applicable to paper, electronic format medical records, and telemedicine.

- Medical Records shall be available to individuals authorized according to policies and procedures for accessing the patient's medical record and as permitted by law.

Medical Records And Communication Of Clinical Information

- Medical Record Requirements
  - Records shall be legible, written in blue or black ink, signed, and dated by the rendering provider for each entry.
    - The electronic format shall also include the name of the provider who made the entry and the date and time for each entry as specified in AAC R9-10-1009
  - Documentation shall be at the time of service, or shortly thereafter.

Medical Records And Communication Of Clinical Information

- Delayed entries within a reasonable timeframe (24-48 hours) are acceptable for purposes of:
  - clarification,
  - error correction,
  - the addition of information not initially available,
  - and if certain unusual circumstances prevented the generation of the note at the time of service.

- Refer to AMPM Policy 940 for current medical record requirements.

Medical Records And Communication Of Clinical Information

Additions, corrections, or changes made after documentation has been finalized must be clearly identified.

- Clearly identify information entered after the original documentation was completed.
- Maintain the integrity of the original medical record when making corrections or changes.
- Follow the requirements in AMPM Policy 940 when adding, correcting, or changing information in the medical record.

Medical Records And Communication Of Clinical Information

Documentation cloning

- Documentation cloning, on paper format or electronic format, is strictly prohibited.
- Pursuant to the Centers for Medicare and Medicaid Services (CMS) sub regulatory guidance:
    - Cloning is the practice involving copying and pasting previously recorded information from a prior note into a new note.
    - The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter.
    - Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable,

Care Coordination
320-O: Behavioral Health Assessments and Treatment Service Planning, AMPM 570 - Provider Case Management, TRBHA

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Care Coordination Across the Healthcare Delivery System

- Per 320-O, FFS providers are responsible for care coordination of AIHP members across all levels of care that include applicable treating providers or entities such as, but not limited to:
  - a. The assigned TRBHA,
  - b. DDD Support Coordinator or DDD District Nurse,
  - c. American Indian Medical Home (AIMH),
  - d. PCP,
  - e. The inpatient and/or outpatient treatment team, including the BHP who shall be responsible for the member's treatment plan,
  - f. The outpatient treatment team may also include Indian Health Services (IHS), Tribally operated 638 Facility, or Urban Indian Health (I/T/U),
  - g. A CFT/ART is not required in order for FFS members to receive services. However, an equivalent team process through the outpatient treatment team is required for care coordination for FFS members, and
  - h. Other individuals of the treatment team including physical and behavioral health providers

Care Coordination

- Per AMPM 570, FFS provider case managers are responsible for monitoring the member's current needs, services, and progress through the regular and ongoing contact with the member, health care decision maker, and designated representative.

- The frequency and type of contact is determined during the treatment planning process and is adjusted and necessary by taking into consideration clinical needs and member preferences.



Care Coordination of BH Assessment & Treatment Plan

- Per AMPM 320-O: All Behavioral health providers shall provide the completed behavioral health assessment, service and treatment plan documentation to the TRBHA or to the Tribal ALTCS case manager, and/or other FFS providers involved in the member's care for inclusion in the member's medical record.



Tribal Regional Behavioral Health Authority (TRBHA)

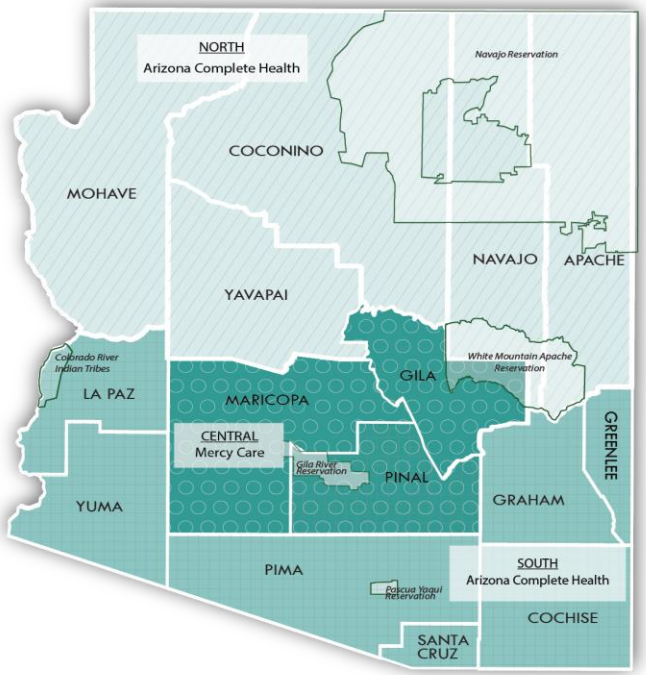
Gila River
- Health Program ID #990010
- BH site code 11

Navajo Nation
- Health Program ID #990030
- BH site code 14

Pascua Yaqui
- Health Program ID #990040
- BH Site code 25

White Mountain Apache
- Health Program ID #990020
- BH Site code 28

ACC-RBHA/TRBHA Map
Effective October 1, 2024



Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.

TRBHA Care Coordination

Pursuant to AMPM 320-O, Fee for Service providers are responsible for coordinating care with the TRBHA if a member is assigned to a TRBHA.

A Release of Information (ROI) is not required for sharing information with the member's assigned TRBHA or Tribal ALTCS, unless records are subject to Part 2 (42 CFR Part 2). Refer to AMPM Policy 940



TRBHA

- Per the PPA, providers are responsible for coordinating and reporting information to the TRBHA of member enrollment. Providers must also cooperate with requests for member information from the TRBHA.
- Providers are responsible for looking at the Behavioral Health (BH) Enrollment in their AHCCCS Online for Member's eligibility for BH services
- Members with an assigned TRBHA will have that TRBHA responsible for their case management and case coordination needs.
- Providers are required to contact the TRBHA to include them in the assessment, treatment planning and discharge planning processes.
- Providers are responsible for responding to the TRBHAs inquiries and coordinating care

Checking Behavioral Health Assignment for Members in AHCCCS Online Provider Portal



Member Eligibility Verification: Eligibility And Enrollment

Print | Hel

Recipient Search | Eligibility And Enrollment | Third Party Liability | CoPayment | Medicare Benefits | **Behavioral Health Services** | Share of Cost | Additional Benefits

Requested Data:			
AHCCCS ID:		**Last Name:**	
DOB:		**First Name:**	
Begin Date of Service:	01/01/2025	**SSN:**	
End Date of Service:	04/04/2025	**Medicare Claim Number OR Medicare Beneficiary ID:**	

Behavioral Health Services

BHS Category	Begin Date	End Date	BHS Site	BHS Service Type
S SMI	10/20/2024		14 NAVAJO NATION	CH MENTAL HEALTH FACILITY - OUTPATIENT

Behavioral Health Services Enrollment



Member Eligibility Verification: Eligibility And Enrollment

Print | He

Recipient Search | Eligibility And Enrollment | Third Party Liability | CoPayment | Medicare Benefits | **Behavioral Health Services** | Share of Cost | Additional Benefits

Behavioral Health Services

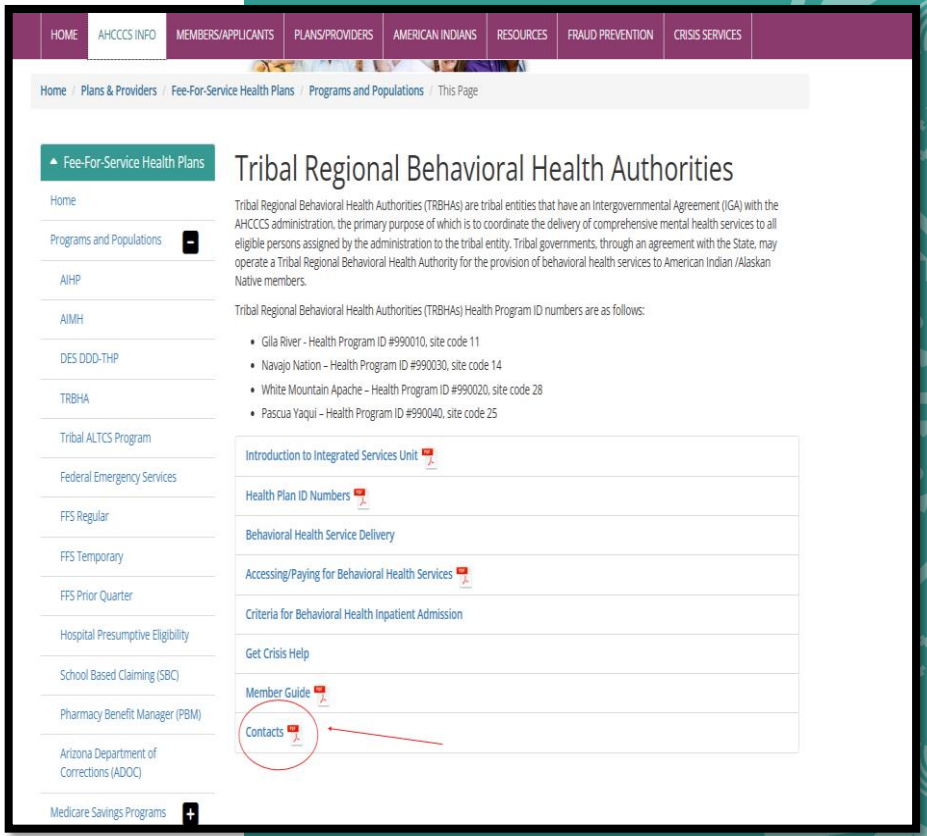
BHS Category	Begin Date	End Date	BHS Site	BHS Service Type
G GENERAL MENTAL HEALTH SERVICES	08/18/2017		39 CENPATICO	CH MENTAL HEALTH FACILITY - OUTPATIENT
G GENERAL MENTAL HEALTH SERVICES	04/01/2017	08/17/2017	39 CENPATICO	CH MENTAL HEALTH FACILITY - OUTPATIENT

BHS Category	Indicates the category of Behavioral Health Enrollment
Begin Date	The effective start date of the recipient's coverage under Behavioral Health Services.
End Date	The date the recipient's coverage under Behavioral Health Services expired.
BHS Site	Name of the TRBHA or RBHA behavioral health agency the recipient is enrolled.
BHS Service Type	Description of the types of services covered under the specified Behavioral Health Services Enrollment.

Contact TRBHA Representatives

AHCCCS Tribal Regional Behavioral Health Authority (TRBHA)

- Select ‘Contacts’
- Open attachment for an updated list of TRBHA contacts



Most Common Deficiencies Identified in Clinical Quality Reviews

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Most Common Deficiencies

This is not a complete list of deficiencies and is for awareness only. Please refer to AHCCCS policies, PPA, FFS Provider Billing Manual, Covered Behavioral Health Service Guide, Licensure, professional standards and coding resources for references.

- Not registered in the QM Portal
  - Not in an active status
- Failure to report IADs in the QM Portal
- Failure to respond to requests for information
- Failure to update provider information (or changes) in APEP
- Failure to coordinate care with the member's treatment team including, TRBHA if enrolled, AIMH if empaneled, or other members of the outpatient treatment team
- Failure to provide BHP Clinical Oversight and Supervision documentation
  - Failure to provide minimum documentation of clinical oversight and supervision
  - Failure to provide oversight of the behavioral health facility and delivery of behavioral health services to members

Common Deficiencies

- Failure to keep the medical record up to date, well organized and comprehensive with sufficient details to promote effective member care and ease of quality review.
- Missing identifiers on the medical record
    - Must include the Member's Name and DOB or AHCCCS ID
- Invalid Signatures:
    - Missing credentials of the signer
    - Missing date and time elements
    - Missing co-signature, if applicable
    - Electronic signatures cannot be word-processed, typed, rubber stamp or copy/paste
    - Provider cannot be on the State Exclusion List
- Failure to have a system in place for EHR validation
    - Failure to authenticate signature
    - Failure to capture and track changes to the medical record

Common Deficiencies

- Treatment plans not individualized to member
  - Not based off the Member's current assessment/evaluation
  - Missing diagnosis(es)
  - Missing goals, objectives, and target or review dates
  - Missing covered services to be provided
  - Missing (or late) signatures and date signed
    - Missing member, HCDM or guardian signature, as applicable
  - No evidence of outpatient treatment team care coordination with member's TRBHA case manager, SMI case manager, AIMH case manager, or other treatment team members.
  - No evidence of discharge planning, aftercare needs, continuity of care addressed or developed throughout the treatment planning process
  - Lack of Safety Planning

Common Deficiencies

- Progress Notes
  - Do not connect back to treatment plan (not member specific)
  - Missing facilitator signature, credentials, date, time
  - Do not include individualized response to treatment activity (member response)
- Assessment/Evaluations
  - No recent assessment or evaluation
  - Conducted by an individual that does not have the skills, training, or credentials qualified to conduct
  - Not signed, dated within time requirements per policy
  - Treatment started prior to assessment of needs
- Group Modifiers
  - Billing that omits mandatory group modifiers; not matching records

Compliance & Monitoring: Memo of Concern & Corrective Action Plan

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Compliance & Monitoring

- Following a Quality Management investigation, if substantiated deficiencies are identified, a provider may receive a Memo of Concern or a Corrective Action Plan.

- A Memo of Concern or Corrective Action Plan is an agreement between the provider and AHCCCS that outlines the actions needed to come into compliance.

- These compliance plans are designed as an opportunity for growth, collaboration, and continuous quality improvement rather than a punitive measure.

Compliance & Monitoring

- The CAP process includes real-time engagement with DFSM Quality Assurance staff who are available to answer questions, clarify requirements, and support improvements for day-to-day operations and procedures.

- DFSM strives to partner with providers to strengthen compliance, improve systems of care, and support sustainable, long-term quality outcomes.

- Providers are also encouraged to watch for upcoming Compliance and Monitoring trainings, which will offer a deeper dive into MOCs and CAPs and highlight the meaningful opportunities these plans provide to support sustainable compliance and quality improvement.

Resources & Links

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HEALTH CARE COST
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Resources

- Quality Management (QM) Portal
- QM Portal User Guide
- Covered Behavioral Health Services Guide
- Tribal Regional Behavioral Health Authorities (TRBHA)
- TRBHA Contact List
- AHCCCS Provider Enrollment Portal (APEP) System
- Provider Participation Agreement (PPA)
- Group Biller Provider Participation Agreement (PPA)
- Guides and Manuals for Health Plans and Providers
- FFS Provider Billing Manual
- FAQs for FFS Programs



Resources

- AHCCCS Medical Policy Manual (AMPM)
- AMPM 310-B Title XIX XXI Behavioral Health Services Benefit
- AMPM 320-0 Behavioral Health Assessment, Service, and Treatment Planning
- AMPM 570 Provider Case Management
- AMPM 610 AHCCCS Provider Qualifications
- AMPM 830 Quality of Care and Fee-for-Service Provider Requirements
- AMPM 940 Medical Records and Communication of Clinical Information
- AMPM 961 Incident, Accident, and Death Reporting



Resources

- State Exclusion List Note: providers must check this list regularly. Any provider found on this list is not eligible to provide services to AHCCCS members.
- Report Fraud Note: Providers are required to report any concerns related to fraud, waste, and/or abuse to the AHCCCS Office of the Inspector General (OIG).
- Sign up for Claims Clues Newsletter, Email Alerts,Training and View Past Trainings Note: Sign up for the Claims Clues Newsletter, email alerts, and training updates to stay informed about important changes and updates. This link also allows you to see previously recorded or published training materials.
- ROPA Requirements Note: Please refer to the ROPA requirements webpage for more information and support with next steps.
- AHCCCS Solutions Center (ASC) Note: To place a service ticket for support from various AHCCCS areas, please ensure you have set up an account within the ASC platform: Getting Started



Upcoming Learning Opportunities (2026)

- FFS Overview of Quality-of-Care Provider Training Overview
  - This training will be posted
- Compliance and Monitoring: CAP/MOC
  - November 17, 2026, from 10:00-11:30 am



- Visit AHCCCS FFS Provider Training Website to view and sign up to receive alerts.
- The Catalyst Behavioral Health Trainings
  - Hosted by Arizona Foundation for Human Service Providers
  - 16 modules that span a variety of topics


We can accomplish more together than we can alone.
Max De Pree
quotefancy

Questions?

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Thank you!

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