ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

DFSM Tribal ALTCS
2ND Quarterly Case Management Supervisory Meeting

Thursday, January 22, 2026

Welcome

Agenda Overview

- Opening Prayer: WMAT ALTCS
- Welcome: Rachel Conley, TALTCS Administrator
- PCSP Updates: Rachel Conley, TALTCS Administrator
- Overview of Member Risk and Goals: Amber Heard, TALTCS Program Manager, and Frank Villarreal, TALTCS Coordinator
- 10 Minute Break
- EDI/EDMS and PA Web Portal Updates: Tianna Tso, Program Specialist
- Clinical Reminders and Updates: Vanessa Torrez, TALTCS Clinical Manager
- 1.5 Hour Lunch
- QM Portal Basics (Portal, Case Closure, Elevation, etc.): Lauren Coln, Program Administrator
- Updated Supervisory Audit Tool: Rachel Conley, TALTCS Administrator
- Quarterly Deliverables: Rachel Conley, TALTCS Administrator
- Closing Remarks: Rachel Conley, TALTCS Administrator

Meeting Reminders

- Please mute your computer's microphone and/or phone when not speaking.
- Use the chat features to add in comments/questions.
- Meetings will no longer be recorded. In-person attendance is strongly encouraged.
- Presentation slides will be uploaded to DTB within 1 week post meeting.

PCSP Updates

Rachel Conley, TALTCS Administrator

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New Planning Review Document

Must be completed if there are no Placement or LOC changes to the initial or Annual PCSP.

I.MEETING INFORMATION
II. PLAN REVIEW AND TEAM FEEDBACK
III. MEDICAL SUPPORTS AND INFORMATION (DOCUMENT ALL CHANGES IN THE DISCUSSION SECTION.)
IV. INDIVIDUAL GOALS AND OUTCOMES Review and write each goal and outcome from the current plan. Indicate if any goals are added, revised or discontinued.
V. CURRENT SERVICE AUTHORIZED

New Planning Review Document (cont.)

VI. SERVICE PLAN MODEL SELECTED
VII. RISKS (Update this section if there is an update on any existing, new, or modified member risk(s).
VIII. MEMBER RIGHTS RESTRICTIONS (Update this section if there is an existing, new or modified member rights restriction reviewed and approved by the Planning Team that includes the following: Member and/or HCDM, Family, Provider(s), and Tribal ALTCS Case Manager.)
IX. ACTION PLAN
X. NEXT MEETING INFORMATION
XI. CONSENT/SIGNATURE

Review Planning Review Document

- Effective 02/01/26
- Document will be uploaded to the Tribal ALTCS Digital Toolbox before effective date.

Questions?

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Overview-Identifying Member Goals

Amber Heard, TALTCS Program Manager

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Goals-Outcomes-Objectives

- **Goals, outcomes and objectives can often be identified by looking at “What works/or working" & “What doesn’t work/or not working" for the member.**
    - *Things to consider, The member wouldn't have become eligible for LTC if everything was going well.*
- **Discussing helps determine what needs to change and what needs to stay the same.**
    - *If member expresses dissatisfaction with aspects of those parts of their life, it opens the door to discussions about what they would like to change/ work on.*
- Ideas for Goals & Objectives can be obtained when discussing the following areas on the PCSP- Preferences & Strengths , Individual Setting and Daily Life.

Goals-Outcomes-Objectives

- **Goals can also reflect what people want to stay the same.**
  - *This may be particularly important when working with the elderly population whose health may be deteriorating. It may be difficult to identify a goal. Consider what they want to maintain.*
  - The goal may stay the same in terms of the desired quality of life, but the outcomes and/or objectives may change as their functioning declines.

Goals-Outcomes-Objectives

- **Remember that Member goals DO NOT include:**
  - Goals that have been determined by the provider without member input.
  - Goals automatically generated based on patient conditions or risk factor, unless that has been identified by the member.
    These items can be discussed and placed on the Action Plan of the PCSP.

Goals-Outcomes-Objectives

- **Functional/Meaningful Outcomes are best derived from questions related to the person's participation in their daily routine.**
  - They are also based on assessed needs, while considering the member's strengths and preferences.
  - They are not written to justify a service. Or based on availability of a service.
- **Functional/Meaningful Outcomes May OR May Not need to be supported by a paid service.**
  - Be sure to explore other sources of support/resources.

Things to consider when developing a goal

- **When identifying a "Health Goal" be sure that it is medically appropriate.**

For example, if a member identifies a goal of "cut out sugar". Does the member have a medical condition related to low/high blood sugar? Do they know their A.1.c #? What other resources could be explored to support the goal? Could their PCP provide a handout of "what to eat'?

Getting more information about something can be an action item to achieve the id entified goal.

Consider if the member has input in the food that is made for them i.e. in a SNF.

Things to consider when developing a goal

- **Make goals measurable and smaller to promote achievement and motivation.**

For example, The member identifies wanting to be "healthy". Member reports they don't drink enough water and has identified goal to drink more water. Consider, How much do they drink now? The member reports 1 glass of water a day. The goal could be to drink 2 glasses of water a day. Consider how the member could track their progress until the next review. Can they keep a tally or mark an X on the calendar every day? Is there someone in their life that could provide daily reminders? Consider medical conditions (i.e fluid restriction? Polydipsia?)

What happens when a goal is achieved?

- When the member does meet their identified goal, how do we keep the motivation?
- Consider what can be done to celebrate the goal being achieved?
- Are there any incentives that your program provides to a member?

Knowledge Check #1 Scenario

You have a member in a Behavioral Health ALF. The member is non-verbal and has an intellectual impairment diagnosis. The member has a guardian because they are unable to make their own decisions. The member cannot participate in goal development in a meaningful way.

Should you document "N/A " or "no goals at this time" in the goal section on the PCSP?

Knowledge Check #1 Discuss

- No, N/A or "no goals at this time" in the goal section on the PCSP .The case manager should work with guardian and ALF staff to develop a measurable- small achievable goal, based on member strengths, preferences & what is working/Not working.
- Located in AMPM 1620-B (5) & AMPM 1620-E (9. j, k & l)
- 1620-B - Needs Assessment Care Planning Standard

Knowledge Check #2 Scenario

You have a member that is at a SNF. He is 23 years old and has a current diagnosis of TBI (Traumatic Brain Injury). He can communicate and express his needs but can be difficult to understand at times. The member's HCDM participates over the phone and reports their goal for the member is for them to remain at the SNF "for the rest of his life".

Would this be considered a person-centered goal?

Knowledge Check #2 Discuss

- No, although the member has an HCDM and they are currently in a SNF, the member still has interests, preferences and may not want to live in a SNF for the duration of their life. We want to continue to reassess members placement, if it is appropriate, could the members needs be met at a lower level of care.

- 1620-E - Service Plan Monitoring and Reassessment Standard

Risk Identification & Assessment

What is a Risk?

- A risk is anything that compromises the member's general health condition and quality of life.
- A specific diagnosis or condition in and of itself, is not a risk. Risks must be assessed for every individual.
- Assessing risks is a balancing between health and safety vs self-determinat ion.
- We are not looking at every risk, but the ones regarding health and safety that could interfere with the person doing what they want.

Risk Identification Process

- **The Risk assessment process consists of:**
  Identifying a risk. Every Member must be assessed for Risk.

  Questions to consider

  - What are the causes/factors contributing to the risk?
  - What are the least restrictive ways to mitigate the risk?
  - What is currently being done to minimize or prevent the risk?
  - Is it working?
  - Are there things that can short of taking away someone's rights?

Identifying Risk

IDENTIFICATION OF RISKS

The following shall be used to identify risks that compromise the member's general health condition and quality of life.

EVERY MEMBER MUST BE ASSESSED FOR RISK.

- Indicate the following, as applicable, next to each risk identified below: **EM** (Effectively Managed); **FA** (Further Assessment); **RR** (Rights Restricted); **MRA** (Managed Risk Agreement)
- If risk is deemed to be EM, the Risk Assessment below shall be used to outline the information and sources utilized in making this determination.
- If FA is needed, the Risk Assessment below shall be used to reflect next steps/how this will/was addressed.
- Consider normal and unusual risks for the member in various areas of the person's life.
- When risks are identified, the team will look for the factors that lead to the risk.
- The team then develops countermeasures and interventions to minimize or prevent the risk.

HEALTH AND MEDICAL RISKS	SAFETY AND SELF-HELP RISKS	MENTAL HEALTH, BEHAVIORAL AND LIFESTYLE RISKS
☐ Allergies:	☐ Access to body of water:	☐ Isolation/isolating behavior:
☐ Aspiration and/or pneumonia infection:	☐ Access to medication:	☐ Military Service/Veteran related illness or injury:
	☐ Access to firearms	
☐ Choking:	☐ Court involvement*:	
☐ Constipation:	☐ Does not or cannot evacuate a home or vehicle in an emergency:	☐ Other Mental Health, Behavioral or Lifestyle Risks: *(loss of loved one, feeling sad, angry, or otherwise "not yourself"?)*:
☐ Dehydration:		
☐ Diabetes:		
☐ Dietary:	☐ Exploitation:	☐ Past or potential police/ justice involvement:
☐ End Stage Renal Disease (ESRD) or on dialysis:	☐ Falls:	
	☐ Household chemical safety:	
☐ Feeding Tube:		☐ Physical aggression:
☐ Heart problems; high or low blood pressure:	☐ Lack of fire safety skills:	☐ Placing in mouth, or ingesting non-edible objects or PICA:
☐ Hepatitis C:	☐ Lack of judgement or difficulty understanding consequences:	
☐ Medical Restrictions:		☐ Property destruction:
☐ Oxygen use:		☐ Self-abusive behaviors:
☐ Pregnancy:		
☐ Refusing medical care:	**MENTAL HEALTH, BEHAVIORAL AND LIFESTYLE RISKS**	☐ Smoking/vaping:
☐ Seizures:		☐ Substance use: drug, alcohol or other:
☐ Serious or chronic health condition(s):	Attempted Suicide:	
	☐ Court involvement*:	☐ Traumatic illness/injury:
☐ Skin breakdown:	☐ Expressed Suicidal Thoughts:	☐ Unsafe use of flammable materials:
Unreported/reported illness:		

Identifying Risk

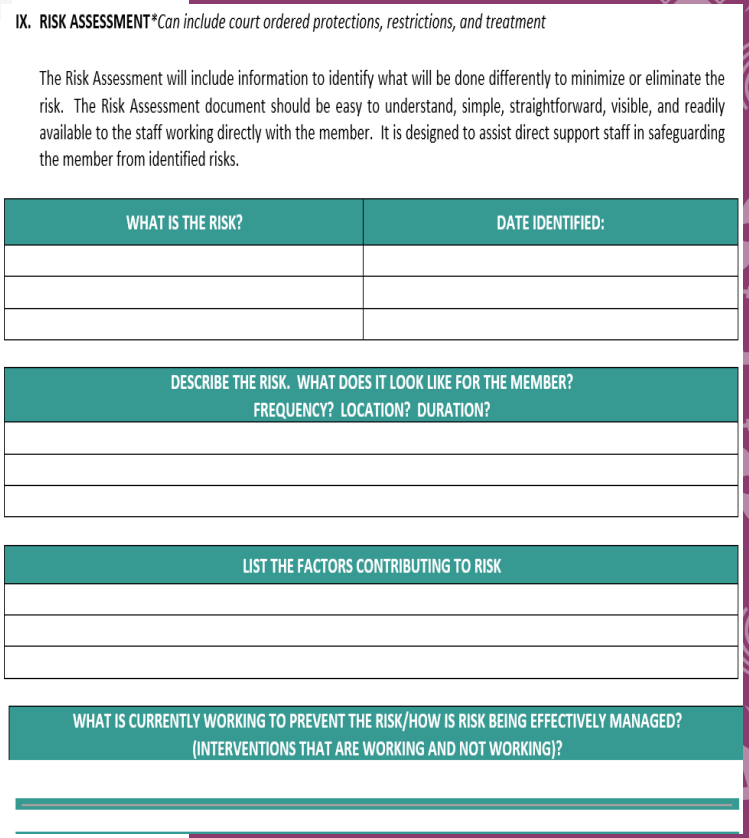
Identify all risks, but not everything needs a risk assessment

- Consider normal and unusual risks for member in various areas of life.
- When risks are identified, the case manager will look for factors that lead to the risk.
- For each identified risk, determine if action is needed and assign a code. Any risk could have more than one code
    - **EM –Effectively Managed**
    - **FA –Further Assessment**
    - **RR –Rights Restricted**
    - **MRA –Managed Risk Agreement**

Every Member Must be Assessed for Risk

- If risk is deemed to be EM, the Risk Assessment shall be used to outline the information and sources utilized in making this determination.

- If FA is needed, the Risk Assessment shall be used to reflect next steps/how this will/was addressed.



IX. RISK ASSESSMENT*Can include court ordered protections, restrictions, and treatment*

The Risk Assessment will include information to identify what will be done differently to minimize or eliminate the risk. The Risk Assessment document should be easy to understand, simple, straightforward, visible, and readily available to the staff working directly with the member. It is designed to assist direct support staff in safeguarding the member from identified risks.

WHAT IS THE RISK?	DATE IDENTIFIED:

DESCRIBE THE RISK. WHAT DOES IT LOOK LIKE FOR THE MEMBER? FREQUENCY? LOCATION? DURATION?

LIST THE FACTORS CONTRIBUTING TO RISK

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK/HOW IS RISK BEING EFFECTIVELY MANAGED? (INTERVENTIONS THAT ARE WORKING AND NOT WORKING)?

Not every risk leads to a risk assessment

Risk Present/acknowledged/no action required=no reduction in rights or their independence. For example,

- **The member has had two heart attacks.**
- **The member has a hearing impairment but doesn't want to wear hearing aids.**
- **The member doesn't have an income.**

Not every risk and health issue is a risk for purposes of HCBS and analysis of a risk or risk assessment. Just having a health diagnosis doesn't count as a risk.

For example, Johnny has diabetes and takes insulin. There are risk related to this – checking feet, blood sugar, etc. but you're not taking away his rights to independence, or he can't go out because of the diabetes. So, you don't have to do a full assessment.

Questions?

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10 Minute Break

EDI/EDMS and PA Web Portal Updates

Tianna Tso, TALTCS Program Specialist

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Update on New PA WebPortal

- Key Features
  - Secure, centralized platform for Tribal Health Plans that supports new and emerging technology for PA processing.
  - Ability to submit PAs, track PA submissions, and access PA decision letters (approvals/denials/missing information).
  - Reduces reliance on faxing and minimizes fax-related issues.
- AHCCCS ISD testing anticipated for Mid-March 2026.
- Target Launch Date: Initially October 2025, December 2025, and now Early to Mid 2026.

Type 99 Provider Transition Update

Health Plan	Fully Completed	Pending EDI Training	Pending Application
Gila River	X		
Pascua Yaqui	X		
Native Health			X
White Mountain			X
San Carlos		X	
Hopi		X	
Tohono O'odham			X
Navajo Nation		X	

Type 99 Provider Registration

- Health Plans must establish a point of contact (POC) for DMPS to complete the 7-step application process and ensure effective collaboration throughout – estimated completion time 1-2 weeks.
  - Application takes approximately 1 day to complete.
  - Once you start the application, you'll have 30 days to complete it in full—otherwise, you'll need to restart the process from the beginning
  - Potential barrier with application process is:
    - AHCCCS System Vendor to obtain Tribal Health Plan Tax ID – takes approximately 2 days to confirm.
    - Provider Social Security information for verification purposes. Social Security information is confidential and is utilized for background verification.

Type 99 Provider Registration Contact

- What common issues or delays have you ran into with the Type 99 application?
- Are there known challenges or barriers that we should be aware of before applying or during the completion of the application?

- For application questions, contact Tianna Tso, Tianna.Tso@azahcccs.gov or Lisa Quihuis, Lisa.Quihuis@azahcccs.gov

EDI Registration

- After completion of the Type 99 Provider application, HP will receive a new HP ID which will be used to re-register in EDI.
  - Will contact HP to set up a meeting to begin the re-registration process and conduct necessary training.
  - The new HP ID should only be used for re-registration of EDI. All HPs will continue to use their 19XXXX IDs.
  - EDI Link: https://servicenow.azahcccs.gov/edi

Questions?

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Clinical Reminders and Updates

Vanessa Torrez, TALTCS Clinical Manager

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Incontinence Supply


Diaper Briefs


Incontinence Pads/Liners


Protective Underwear


Underpads


Accessories

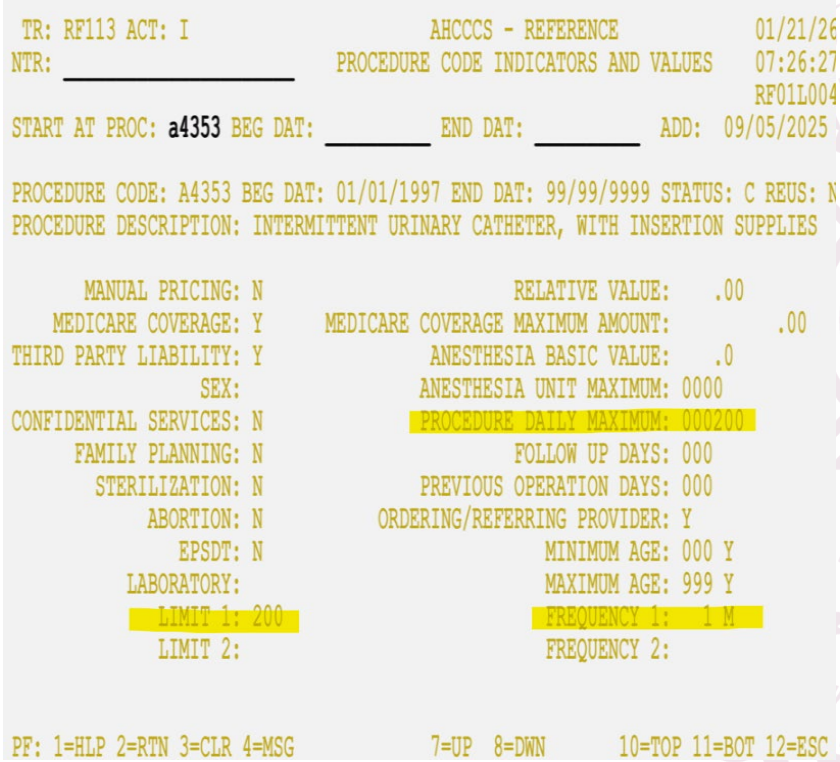
- Briefs
- Incontinence Pads/Liners
- Chuxs / Underpads
- Wipes / Accessories

- ****Prior Authorizations will begin to be extended at a 6 month interval based on review and medical necessity , Please ensure Rx covers DOS. If a new Rx is needed the PA will be extended up to expiration of Rx. ANY Changes in quantity , item , condition ect will require a new PA packet for review.**

PMMIS Screen: RF113 Reference Code Indicators & Values

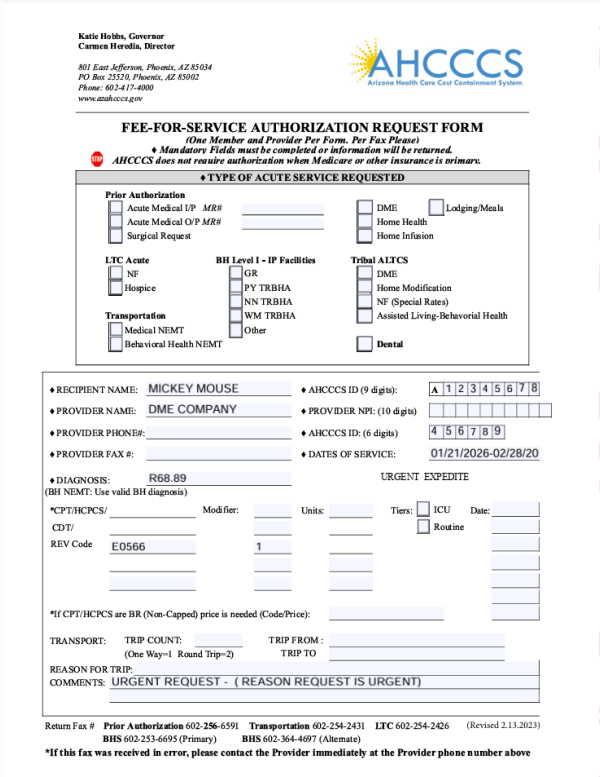
- Type in HCPCS code
- Hit enter
- Code indicators and values will display.

- Note: keep in mind the value displayed can differ per AMPM. Any overlimit qty shown will need medical justification to be sent to Medical Review.



Urgent/Expedited Prior Authorization Requests

- Urgent / Expedited Prior Authorization should be submitted with supporting documentation, AND an email must be made to Tribal ALTCS to notify PA staff that a request requiring expedited review has been submitted.
  *Note : Submission of request on short notice does not constitute an urgent request. An urgent / expedited request can take up to 3 days to review. Requests submitted as urgent that are determined to be routine in nature will be processed in accordance with standard review timeframes, ie. within 14 days.



Katie Hobbs, Governor
Carmen Heredia, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS
Arizona Health Care Cost Containment System

FEE-FOR-SERVICE AUTHORIZATION REQUEST FORM

(One Member and Provider Per Form. Per Fax Please)
♦ Mandatory Fields must be completed or information will be returned.
AHCCCS does not require authorization when Medicare or other insurance is primary.

♦ TYPE OF ACUTE SERVICE REQUESTED

Prior Authorization
- ☐ Acute Medical I/P *MR#*
- ☐ Acute Medical O/P *MR#*
- ☐ Surgical Request
- ☐ DME ☐ Lodging/Meals
- ☐ Home Health
- ☐ Home Infusion

LTC Acute
- ☐ NF
- ☐ Hospice

BH Level I - IP Facilities
- ☐ GR
- ☐ PY TRBHA
- ☐ NN TRBHA
- ☐ WM TRBHA
- ☐ Other

Tribal ALTCS
- ☐ DME
- ☐ Home Modification
- ☐ NF (Special Rates)
- ☐ Assisted Living-Behavorial Health

Transportation
- ☐ Medical NEMT
- ☐ Behavioral Health NEMT

☐ **Dental**

♦ RECIPIENT NAME: MICKEY MOUSE
♦ AHCCCS ID (9 digits): A 1 2 3 4 5 6 7 8
♦ PROVIDER NAME: DME COMPANY
♦ PROVIDER NPI: (10 digits)
♦ PROVIDER PHONE#:
♦ AHCCCS ID: (6 digits) 4 5 6 7 8 9
♦ PROVIDER FAX #:
♦ DATES OF SERVICE: 01/21/2026-02/28/20
♦ DIAGNOSIS: R68.89 URGENT EXPEDITE
(BH NEMT: Use valid BH diagnosis)

*CPT/HCPCS/ CDT/	Modifier:	Units:	Tiers:	Date:
REV Code E0566		1	☐ ICU ☐ Routine	

*If CPT/HCPCS are BR (Non-Capped) price is needed (Code/Price):

TRANSPORT: TRIP COUNT: (One Way=1 Round Trip=2) TRIP FROM : TRIP TO
REASON FOR TRIP:
COMMENTS: URGENT REQUEST - (REASON REQUEST IS URGENT)

Return Fax # **Prior Authorization** 602-256-6591 **Transportation** 602-254-2431 **LTC** 602-254-2426 (Revised 2.13.2023)
BHS 602-253-6695 (Primary) **BHS** 602-364-4697 (Alternate)
If this fax was received in error, please contact the Provider immediately at the Provider phone number above

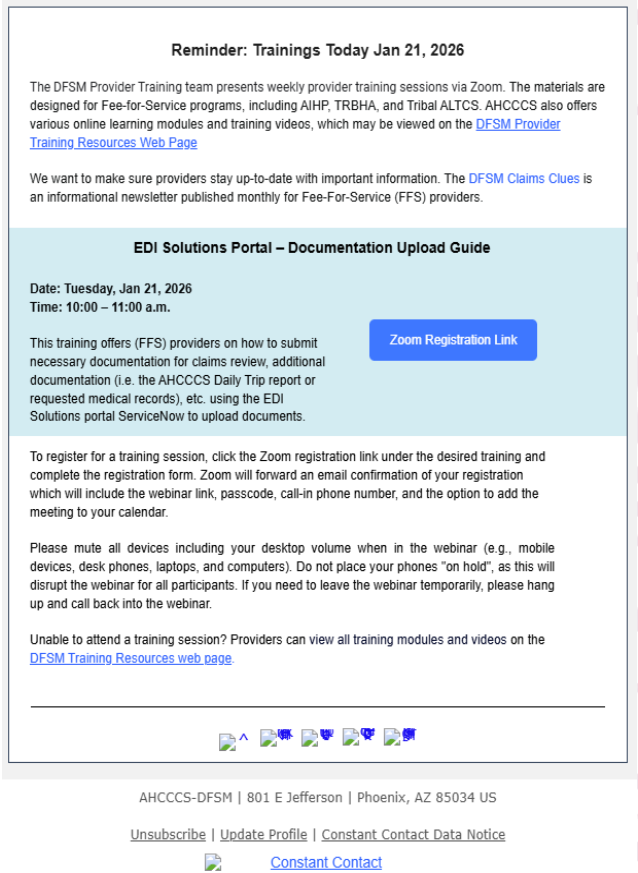
Acute PA Requests

- Acute PA requests for Tribal ALTCS members must be faxed into DFSM: **1-602-256-6591 .**
    - If a Provider gets directed to you, instruct the Provider: "The Provider would need to fax to DFSM Fax number: 602-256-6591. Please ensure to write "Acute Care Service" on the fax cover sheet."
- If the Provider states they are being informed to contact CM by DFSM , please request a name of who they are getting the misinformation from.
- Provider can submit service ticket using ServiceNow
- Identify Member is Tribal ALTCS with HP – Acute Care Service – Assistance Needed.

Division of Fee for Service Management: Training Resources

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html
- How to sign up for DFSM **email alerts**: (Full link below)
  - https://visitor.r20.constantcontact.com/manage/optin?v=001gF-kjPbNwUl4qTFXa25yg7PI-lJiYCg93XrtPtORBVs5LfBVH0-8vbcm12yD-2XXtSsqiYUBOmMmlkrI8ahm_2YiyBfBDlwfmRmEGrovUOSP6DcA-KbmT-Ql0Lmk0PExgqaWuvz6fV2kNwVjevvO11fbEYfxSl5MtPdTd_x0b-d44ezL3scdyI-S4QgYEsLUgwtSDvtSPxE%3D

Example of Constant Contact



Reminder: Trainings Today Jan 21, 2026

The DFSM Provider Training team presents weekly provider training sessions via Zoom. The materials are designed for Fee-for-Service programs, including AIHP, TRBHA, and Tribal ALTCS. AHCCCS also offers various online learning modules and training videos, which may be viewed on the DFSM Provider Training Resources Web Page

We want to make sure providers stay up-to-date with important information. The DFSM Claims Clues is an informational newsletter published monthly for Fee-For-Service (FFS) providers.

EDI Solutions Portal – Documentation Upload Guide

Date: Tuesday, Jan 21, 2026
Time: 10:00 – 11:00 a.m.

This training offers (FFS) providers on how to submit necessary documentation for claims review, additional documentation (i.e. the AHCCCS Daily Trip report or requested medical records), etc. using the EDI Solutions portal ServiceNow to upload documents.

Zoom Registration Link

To register for a training session, click the Zoom registration link under the desired training and complete the registration form. Zoom will forward an email confirmation of your registration which will include the webinar link, passcode, call-in phone number, and the option to add the meeting to your calendar.

Please mute all devices including your desktop volume when in the webinar (e.g., mobile devices, desk phones, laptops, and computers). Do not place your phones "on hold", as this will disrupt the webinar for all participants. If you need to leave the webinar temporarily, please hang up and call back into the webinar.

Unable to attend a training session? Providers can view all training modules and videos on the DFSM Training Resources web page.

AHCCCS-DFSM | 801 E Jefferson | Phoenix, AZ 85034 US

Unsubscribe | Update Profile | Constant Contact Data Notice

Constant Contact

Questions?

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Lunch – 1.5 Hour

Division of Fee-for-Service Management (DFSM)

Quality of Care Policies and QM Portal Overview

January 22, 2026

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DFSM Quality of Care Policies and QM Portal Overview Facilitators

Lauren Coln, MSN, RN
Quality Administrator

Shannon Shiver
Quality Management
Manager

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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)

DFSM is responsible for the clinical, administrative and claims functions of the Fee-For-Service Population (FFS), consisting of more than 250,000 members, including:

- American Indians/Alaska Natives (AI/AN) enrolled in the American Indian Health Program (AIHP) for acute and behavioral health care
- AIHP members enrolled with a Tribal Regional Behavioral Health Authority (TRBHA) for the coordination of behavioral health services
- AI/AN members enrolled with Tribal Arizona Long Term Care System (ALTCS)
- Individuals in the Federal Emergency Service population (FES).

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 Medical Policy Manual (AMPM)

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AHCCCS Medical Policy Manual

The AMPM provides guidance to contractors and their delegated subcontractors, along with providers regarding services covered under the AHCCCS Program. The AMPM operates with authority in conjunction with federal and state regulations, other agency guides and manuals, and applicable contracts.

The 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 (FESP),
- DDD-Tribal Health Program (DDD THP).

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 24 hours after discovering the issue. Reports should be submitted through the QM portal.

- Tribal ALTCS shall report via the Internal Referral Form (IRF) process and elevate to AHCCCS QM as needed.

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

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 (cont'd)

g. Medication error occurring at a licensed residential 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), or

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.

ix. An inpatient provider site, and

x. An outpatient Treatment Center (OTC)

AMPM 961 Reportable IADs (cont'd)

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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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

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,

Sentinel IADs (cont'd)

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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Quality Management (QM) Portal

- Per the PPA and AHCCCS QM Policies, providers must be registered in the AHCCCS Quality Management Portal within 30 days of becoming active
    - QM Portal: https://qmportal.azahcccs.gov/
- Tribal ALTCS programs shall also register in the QM Portal designating a Master Account Holder.
- Master Account holder(s) may designate and approve other individuals to have access and assist with their program's review and case closure of IADs/QOCs.
    - IRFs are created by the health program or plans (i.e. ALTCS, TRBHA)

AHCCCS Reporting Forms

- Incident, Accident, Death (IAD) – Reported by every Provider to the respective Health Program, Health Plan, TRBHA, Tribal ALTCS.

- Internal Referral Form (IRF) – Reported by the Health Program, Health Plan, TRBHA, Tribal ALTCS. This form is created on behalf of a Provider who fails to report and for example a case manager is aware of a reportable incident.

- Quality of Care Concern (QOC) – If the IAD or IRF contains quality of care elements, then the program or plan shall change their status to a QOC.

QM Portal (cont'd)

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

Home

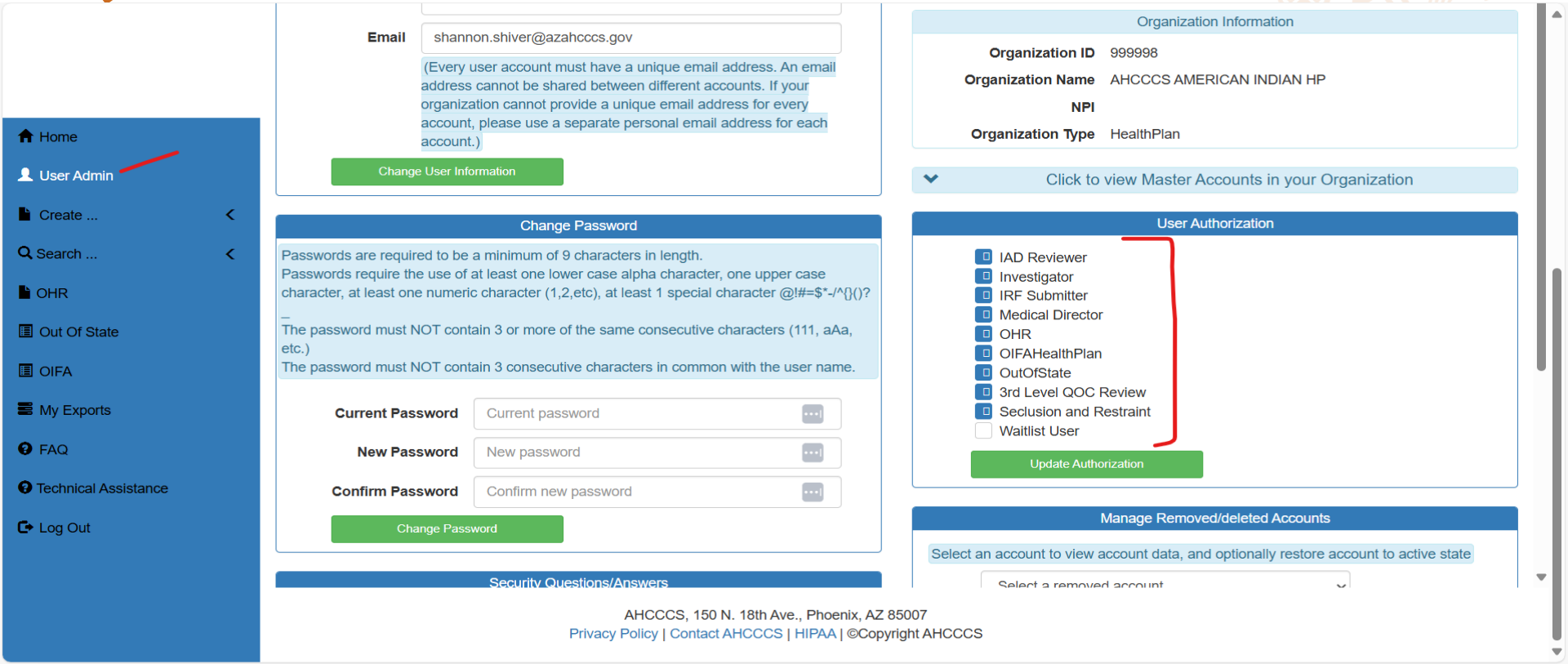
FAQ

Help and Support

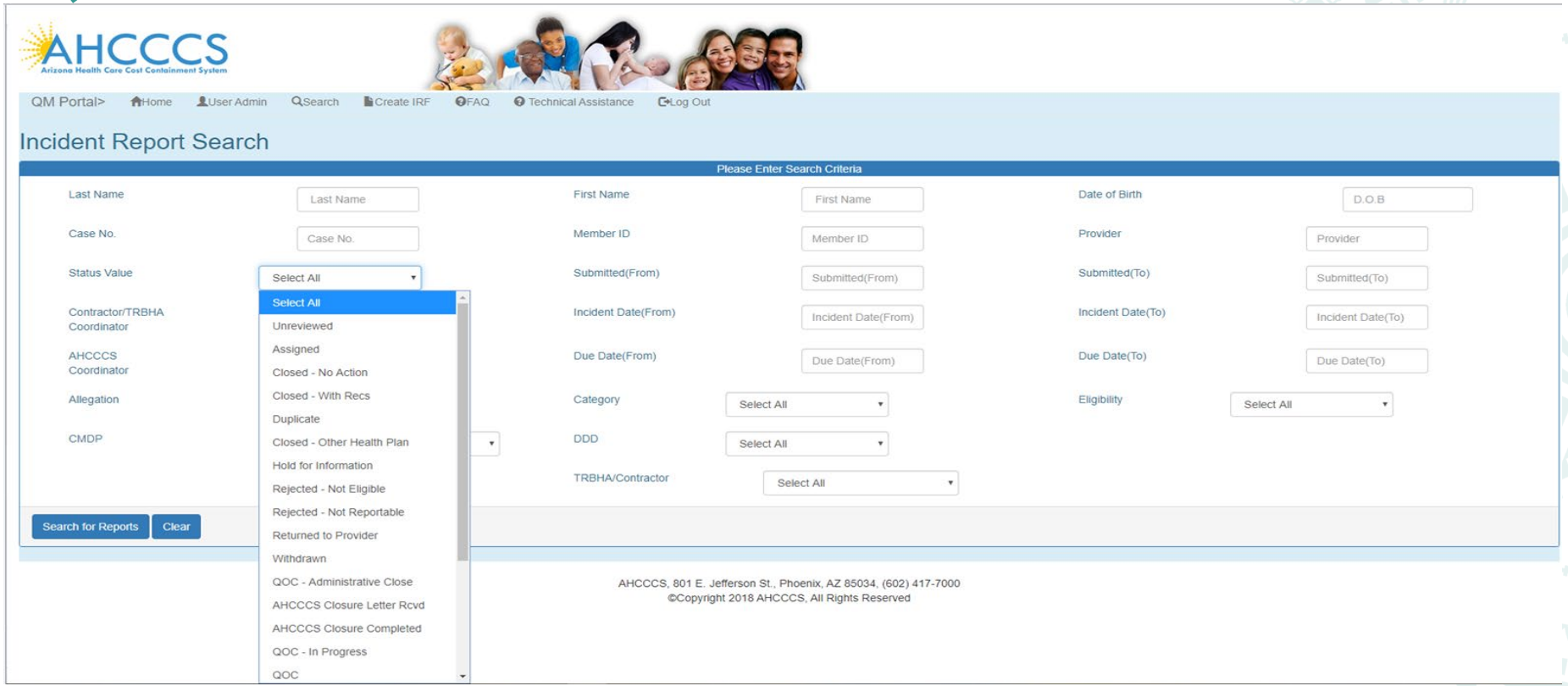
Thank you for visiting QM Portal. If additional questions arise, please contact our Customer Support Center at **(602) 417-4451** or contact **servicedesk@azahcccs.gov**.

- Registration
- IAD-IRF Reporting
- Quality of Care Reporting
- Office of Human Rights Notifying
- Independent Oversight Committee
- Seclusion And Restraint Application
- Waitlist Application
- Out Of State Application
- Office Of Individual and Family Affairs
- Practice and Provider Information Changes

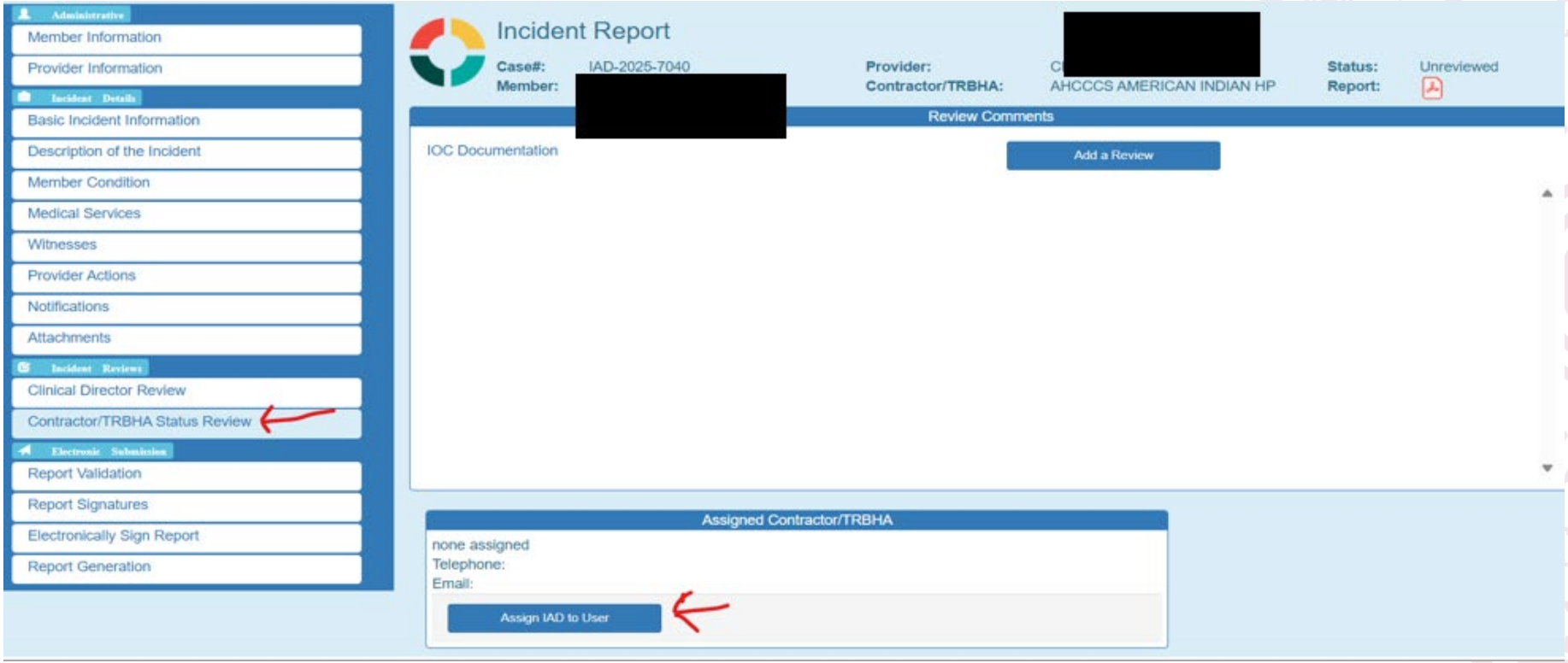
QM Portal Permissions



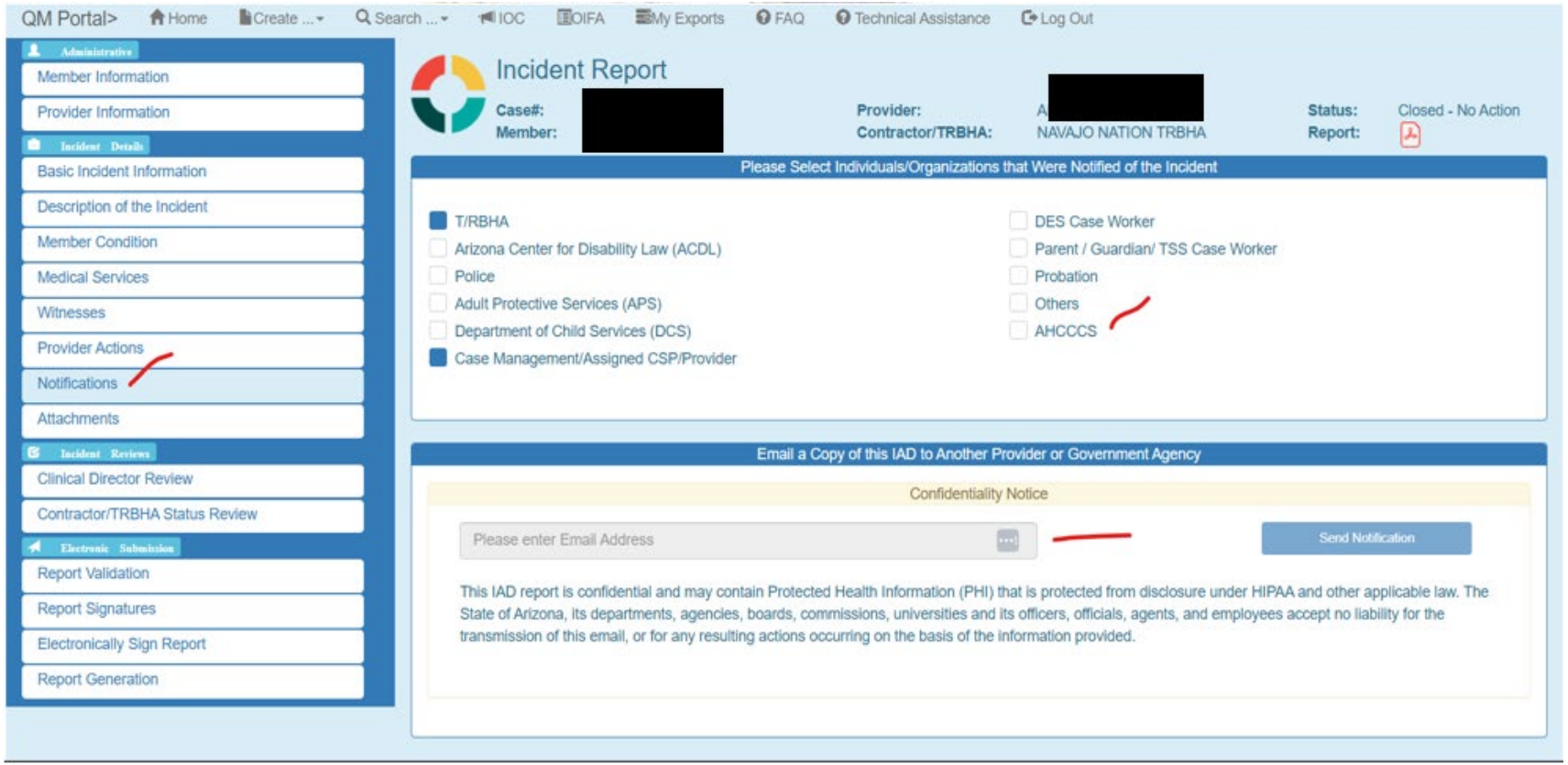
QM Portal view



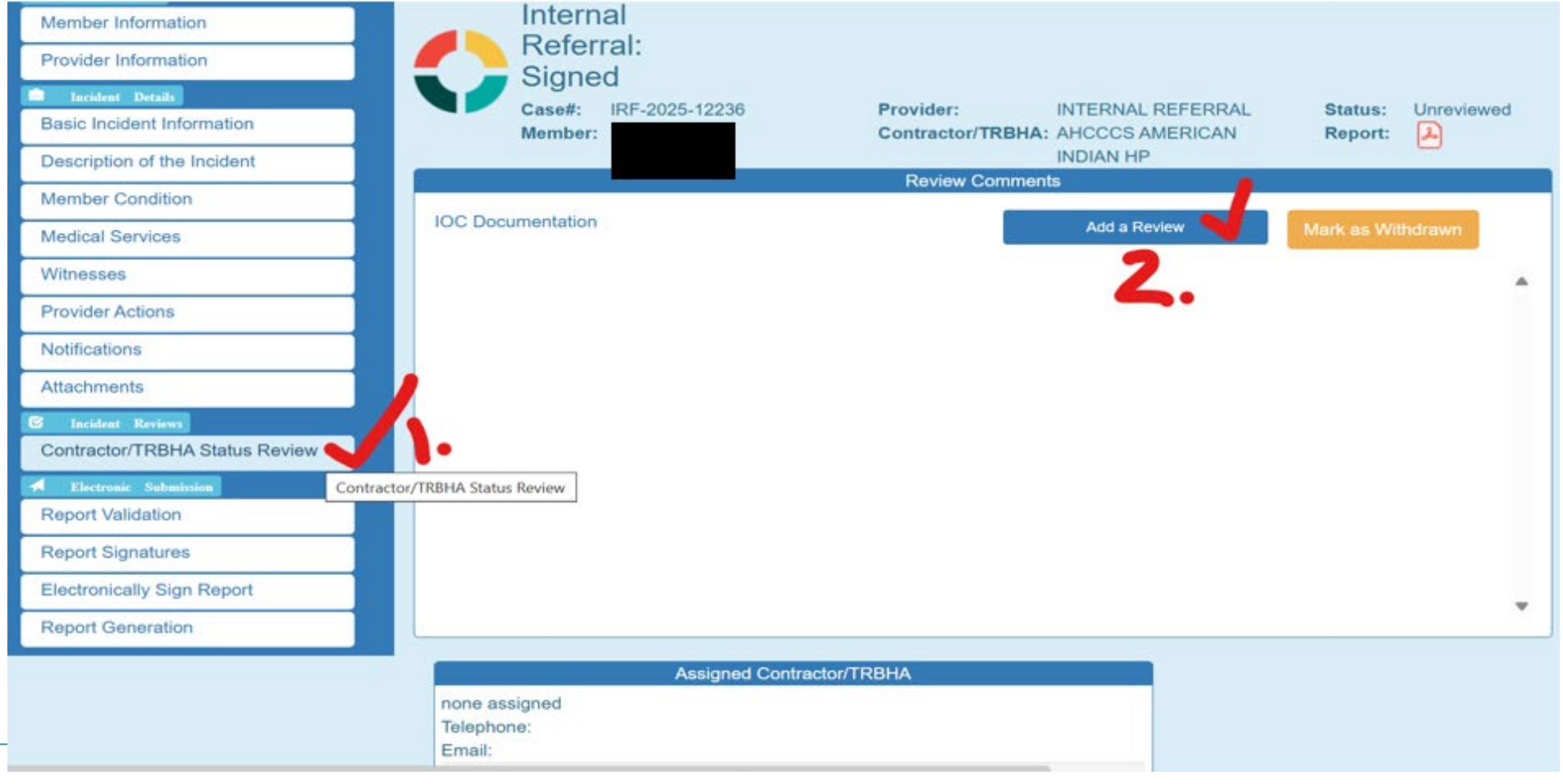
QM Portal – Assigning Cases



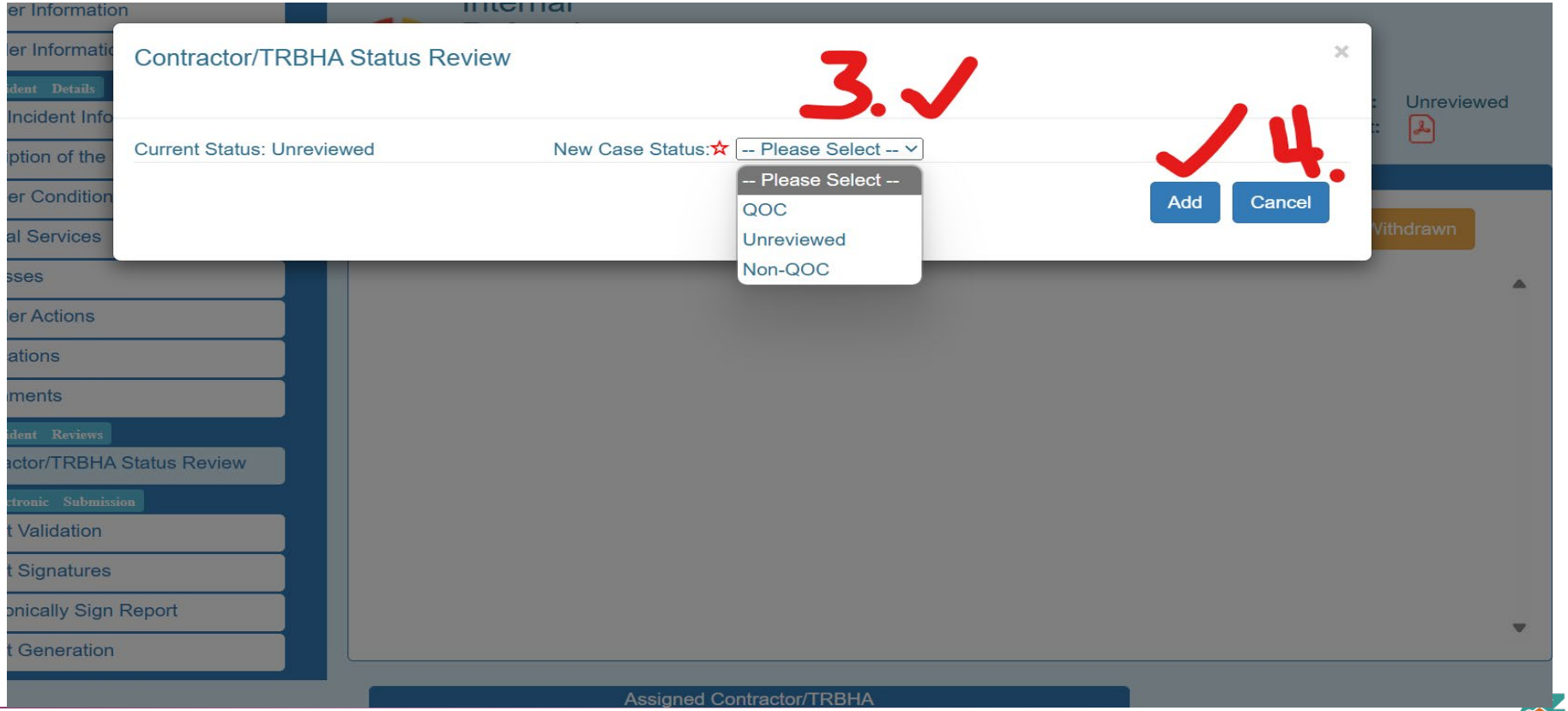
Notification of IAD



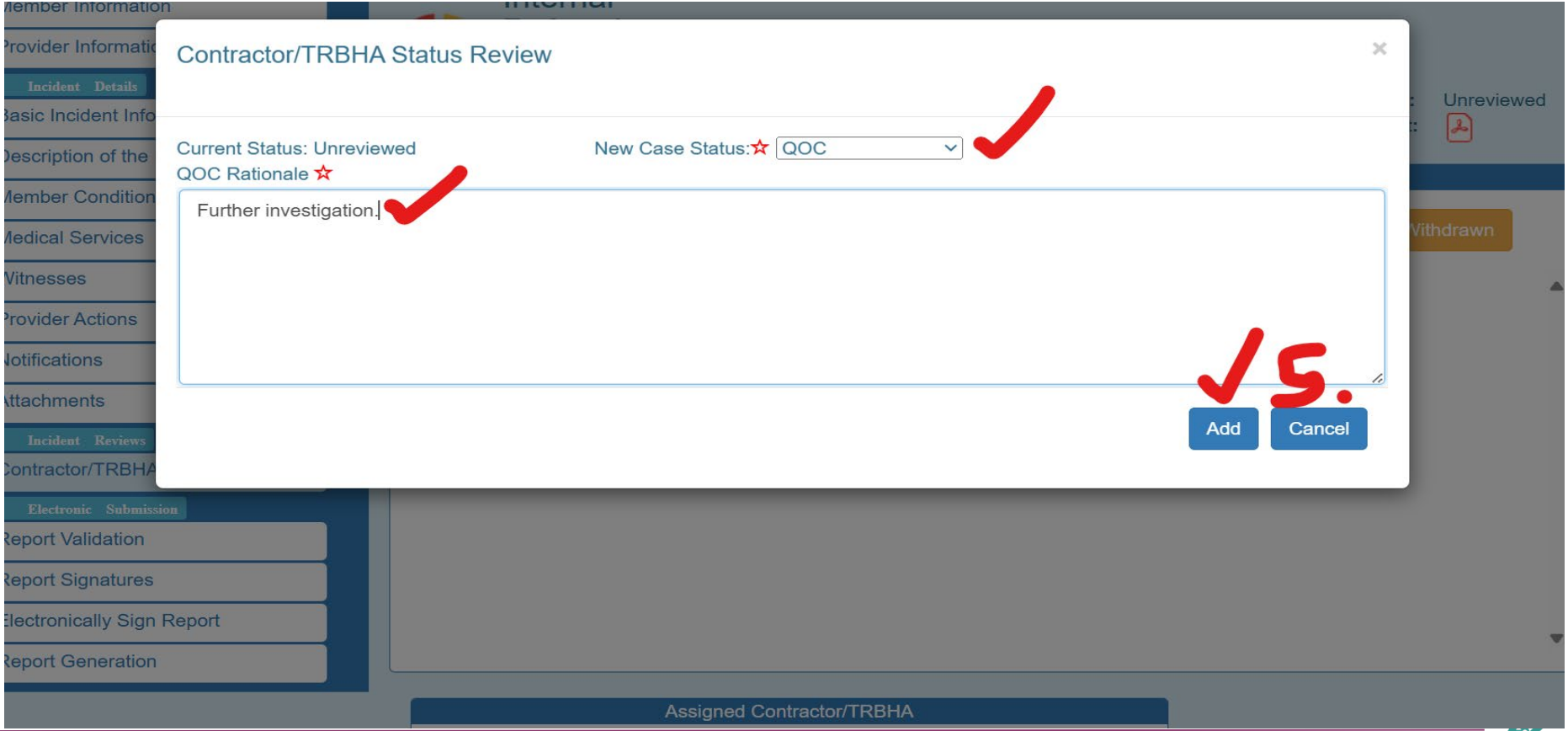
IAD or IRF to QOC Status



Creating the QOC status



Creating the QOC status



QOC Menu Items to Complete

QM Portal> Home Create ... Search ... IOC OIFA My Exports FAQ Technical Assistance Log Out

Quality of Care - Case Manager

Case#: IRF-2025-15410
Member: [redacted]

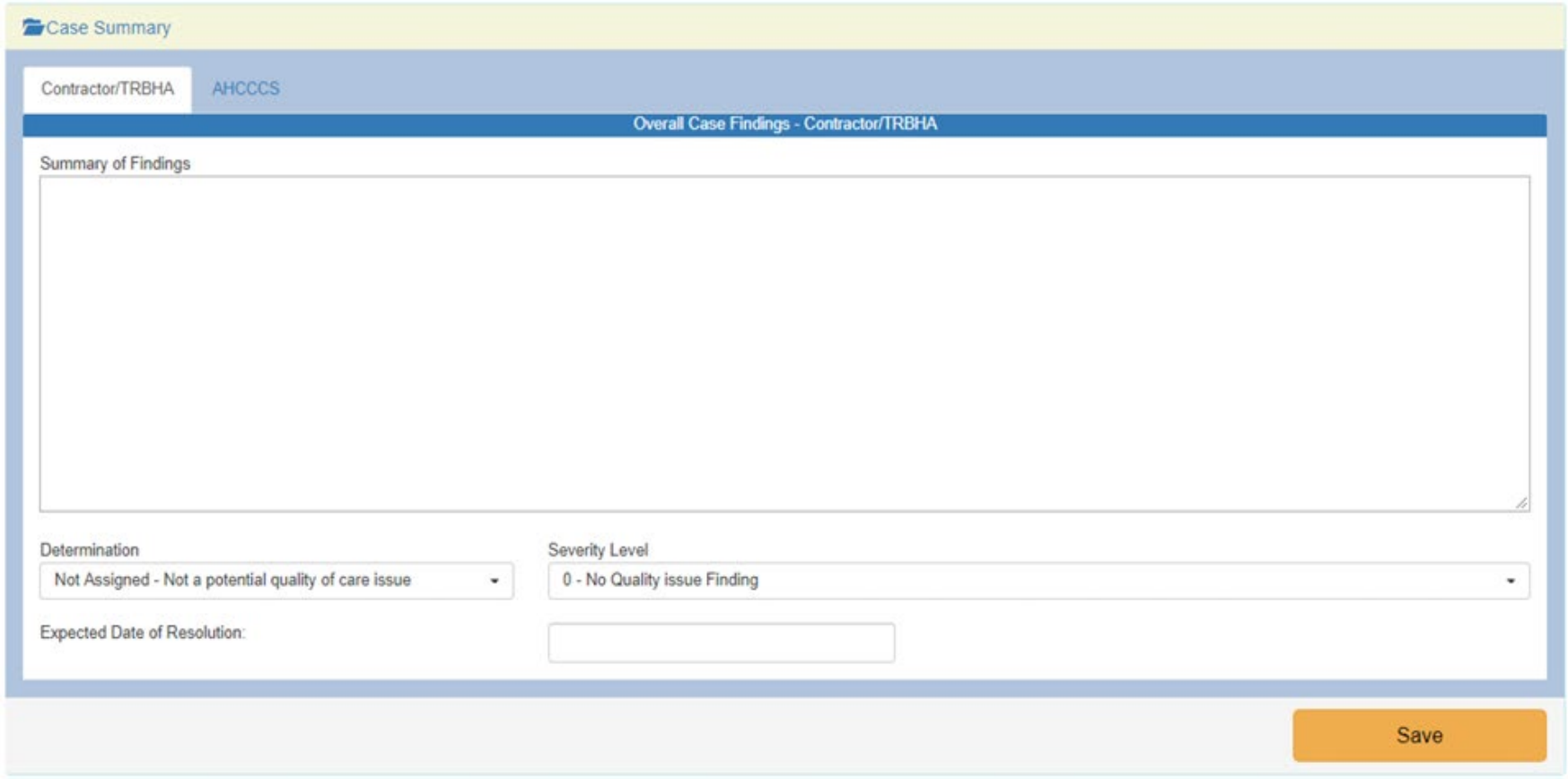
Provider: INTERNAL REFERRAL
Contractor/TRBHA: NAVAJO NATION TRBHA

- Provider Information
- Member Information
- Clinical and Diagnosis
- Treatment Information
- QOC Referral Information
- Information Sources
- Timeline (optional)
- Allegations

QOC Menu Items to Complete

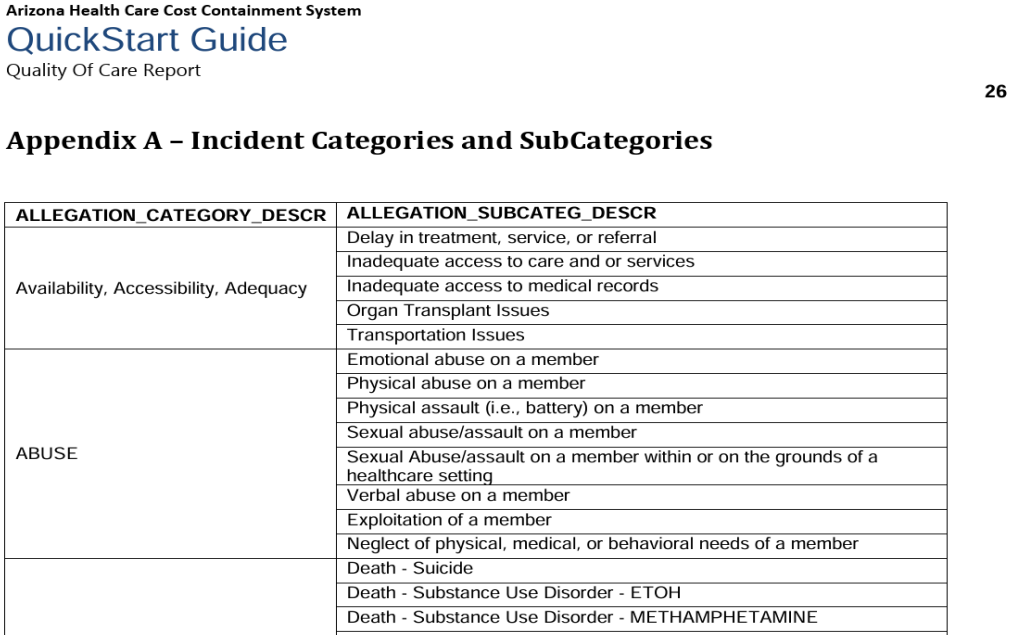
- Allegations
- Case Summary
- Attachments
- Amendments
- Electronic Signatures
- QOC Tracking
- Independent Oversight Committee Document Redaction/Release

Summary of Findings



QM Portal Quick User Guide

- https://qmportal.azahcccs.gov/UserGuides/QuickStart_QOC_Report.pdf



Arizona Health Care Cost Containment System

QuickStart Guide

Quality Of Care Report

Appendix A – Incident Categories and SubCategories

ALLEGATION_CATEGORY_DESCR	ALLEGATION_SUBCATEG_DESCR
Availability, Accessibility, Adequacy	Delay in treatment, service, or referral
	Inadequate access to care and or services
	Inadequate access to medical records
	Organ Transplant Issues
	Transportation Issues
ABUSE	Emotional abuse on a member
	Physical abuse on a member
	Physical assault (i.e., battery) on a member
	Sexual abuse/assault on a member
	Sexual Abuse/assault on a member within or on the grounds of a healthcare setting
	Verbal abuse on a member
	Exploitation of a member
	Neglect of physical, medical, or behavioral needs of a member
	Death - Suicide
	Death - Substance Use Disorder - ETOH
	Death - Substance Use Disorder - METHAMPHETAMINE

Summary of Findings: Severity Level Case Outcome

The severity levels are defined as follows:

- Level 0: (Track and Trend Only) - No Quality issue Finding.
- Level 1: Quality issue exists with *minimal potential* for significant adverse effects to the patient/recipient.
- Level 2: Quality issue exists with *significant potential* for adverse effects to the patient/recipient if not resolved timely.
- Level 3: Quality issue exists with *significant adverse effects* on the patient/recipient; is dangerous and/or life-threatening.
- Level 4: Quality issues exist with the *most severe adverse effects* on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others.

Summary Findings: Final Determination Case Outcome

- **Not Assigned:** Not a potential quality of care issue (no clinical investigation required)
- **Substantiated**: Quality of care issue(s) confirmed (following clinical investigation)
- **Unsubstantiated:** No quality of care issue(s) (following clinical investigation)
- **Unable to Substantiate:** Unable to substantiate a quality of care issue (following clinical Investigation)

- After this step, the case is closed.

Next Steps

- If you need any support, additional one-on-one training or technical assistance, please reach out to Rachel and team to coordinate an appointment with DFSM Quality Management Administration.

- If you are not sure who your QM Portal Master Account Holder is, please reach out to DFSM for support.

- DFSM Quality Management Email: DFSMQualityManagement@azahcccs.gov

- Quality Management (QM) Portal
- QM Portal User Guide
- Covered Behavioral Health Services Guide
- 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
- AHCCCS Medical Policy Manual (AMPM)
    - AMPM 830 Quality of Care and Fee-for-Service Provider Requirements
    - AMPM 960 Quality of Care Concerns
    - AMPM 961 Incident, Accident, and Death Reporting

- 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, Waste, or Abuse
  - 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, and Training
  - Note: Sign up for the Claims Clues Newsletter, email alerts, and training updates to stay informed about important changes and updates.
- ROPA Requirements
  - Please refer to the ROPA requirements webpage for more information and support with next steps.

Questions?

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Quarterly Supervisory Audit Tool Updates

Rachel Conley, TALTCS Administrator

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

CMCS Published Regulation

States must submit metric data from and about their Medicaid Enterprise System (MES) modules to be eligible to receive enhanced federal matching for MES system expenditures.

- LTSS1: Percent of notifications and decisions sent to the correct individuals within the required timeframe.
- LTSS2: Percentage of beneficiaries with proof of consent stored in system
- LTSS3: Verify assigning and changing of beneficiary prioritization.
  Verify assigning and changing waitlist status.
  Verify researching and finding prioritization and waitlist status.
  Verify ability to report on waitlist and prioritization status.
- LTSS4: Verify ability to update beneficiary records for death, loss of eligibility
- LTSS5: Percentage of beneficiaries with current and complete person-centered plan

CMCS Published Regulation (cont.)

- LTSS6: Verify that only correctly assigned/authorized logins can view care plans.
- Verify that 'not authorized logins' are unable to view plans.
- Verify that 'not authorized logins' cannot update or change data.
- LTSS8: Verify the capability to save and track prior authorization information on LTSS beneficiaries.
- LTSS9: Average number of days it takes from a critical incident to completion of an administrative review

The Supervisory Audit tools have been updated to ensure the Tribal ALTCS Program are meeting the pulished regulation.

The new and updated Audit Tools (Supervisor & Individual Member) will be posted on the Tribal ALTCS Digital Toolbox on the AHCCCS webpage by February 01, 2026.

Questions?

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Closing Remarks

Rachel Conley, Tribal ALTCS Administrator

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM