ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

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

Quality of Care Overview
April 8th, 2025

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 vast 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 Long Term Care 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 FFS 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)

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 within 30 days of 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. This notice shall be sent to apeptrainingquestions@azahcccs.gov.
- The closure and the reason for closure must be posted at the entrance of the facilities.
- A provider must report in APEP a change in servicing address at least 30 days prior to the effective date of the change.
- Providers shall report Behavioral Health Professional (BHP) changes.

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 Manageme
  - 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 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 (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.

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 enrolled members, the TRBHA may investigate the case

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

On-Site Visits
What to Expect

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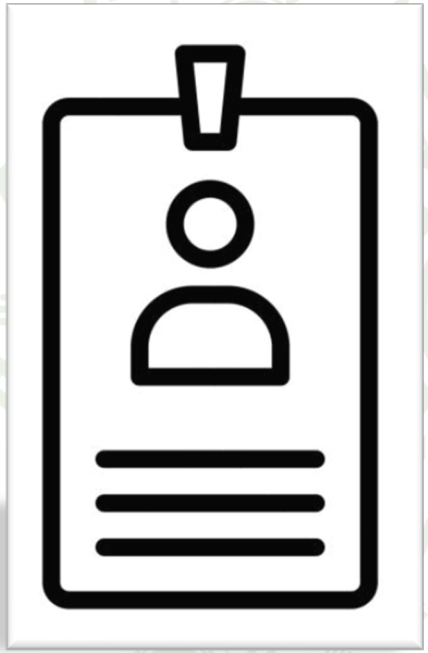
On-site Visits

- 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 (Cont'd)

- 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 (Per FFS Billing Manual Chapter 3)
  - Interview Members
  - Interview Clinical or Medical Director, BHP, BHMP, or other facility staff



Most Common Deficiencies Identified in Clinical Quality Reviews

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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.

- Failure to report IADs
- Failure to respond to requests for information
- Not registered in the QM Portal
  - Not in an active status
- 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 update provider information in APEP
- 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 (Cont'd)

- Failure to keep 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 (Cont'd)

- Treatment plans not individualized to member
  - Not based off the Member's 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 (Cont'd)

- 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

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.

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

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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,

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

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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 (cont'd)

- 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 contact servicedesk@azahcccs.gov.

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

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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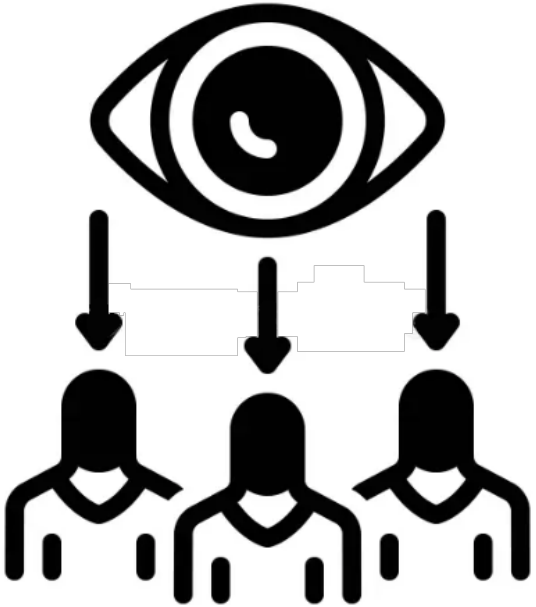
BHP Clinical Oversight and Supervision



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.

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 personnel.
- Changes to BHP must be reported in APEP according to policy
- Providers must disclose adverse actions to AHCCCS

AMPM 940- Medical Records and Communication of Clinical Information

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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.
- The Contractor and Fee-For-Service (FFS) providers shall ensure via regular monitoring activities that documentation completed and maintained by the providers, meets the requirements specified in AMPM 940.

Medical Records And Communication Of Clinical Information (Cont'd)

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.

Care Coordination

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

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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:
  - i. The assigned TRBHA,
  - ii. DDD Support Coordinator or DDD District Nurse,
  - iii. American Indian Medical Home (AIMH),
  - iv. PCP,
  - v. The inpatient and/or outpatient treatment team, including the BHP who shall be responsible for the member's treatment plan,
  - vi. The outpatient treatment team may also include Indian Health Services (IHS), Tribally operated 638 Facility, or Urban Indian Health (I/T/U), and/or
  - vii. Other individuals of the treatment team including physical health providers, as applicable which may or may not include optional utilization of Child Family Team (CFT) or Adult Recovery Team (ART).

Care Coordination

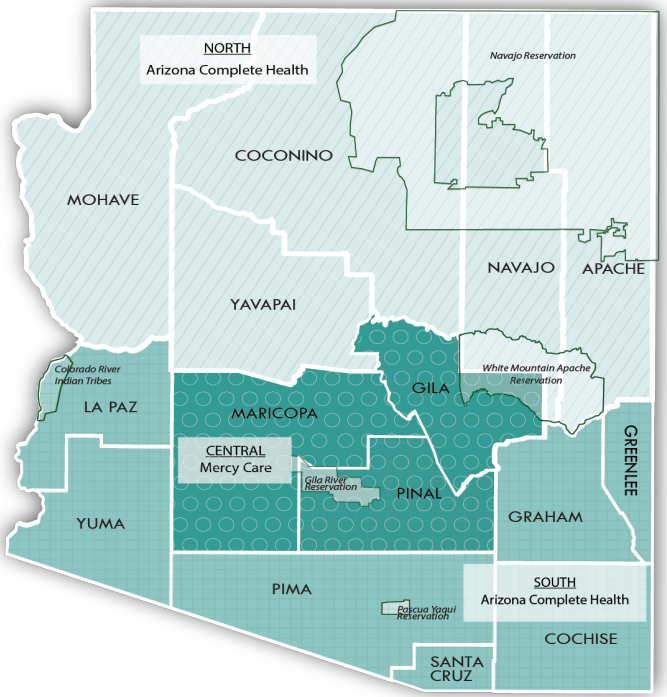
- Per AMPM 570, FFS provider case managers are responsible for monitoring the member's current needs, services, and progress through the regular and ongoing contact with the member, health care decision maker, and designated representative.
- The frequency and type of contact is determined during the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

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.

- **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

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 Provider Participation Agreement (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

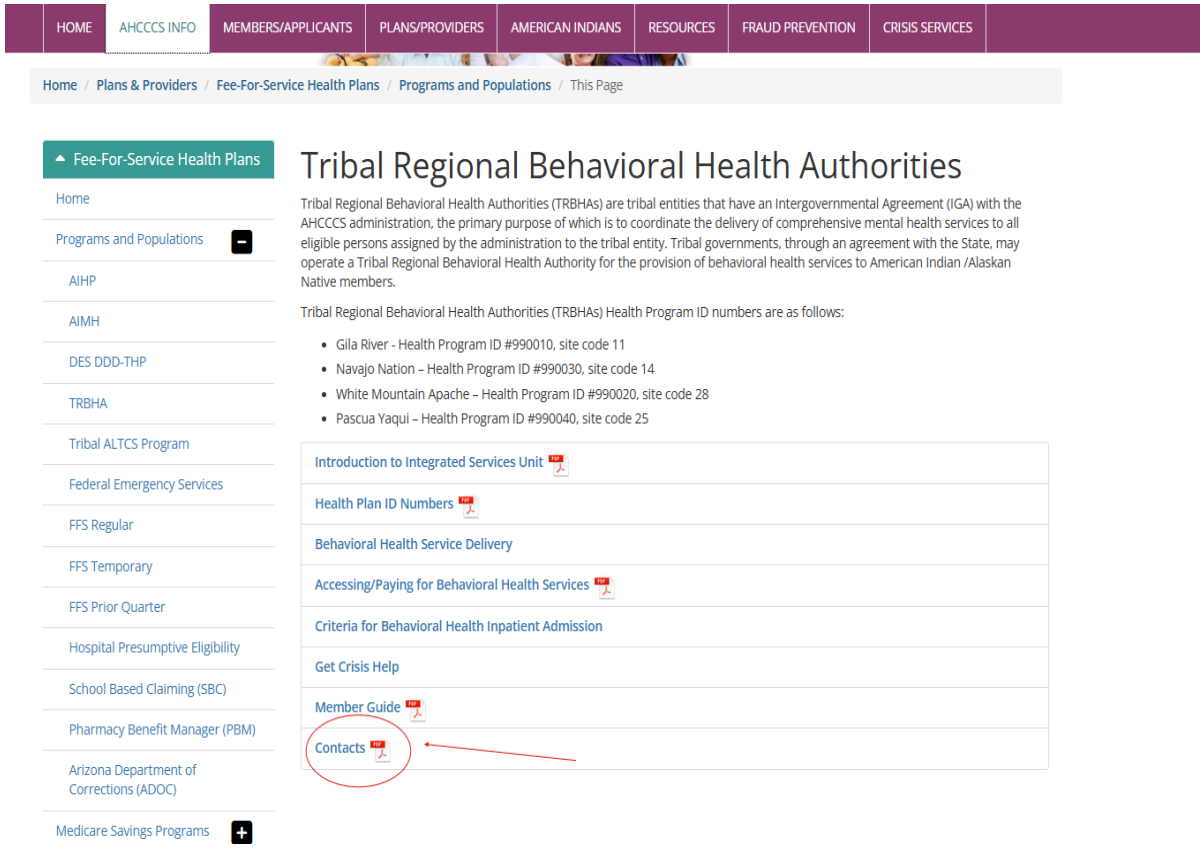
Requested Data:			
AHCCCS ID:		**Last Name:**	
DOB:		**First Name:**	
Begin Date of Service:	01/01/2025	**SSN:**	
End Date of Service:	04/04/2025	**Medicare Claim Number OR Medicare Beneficiary ID:**	

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

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

Compliance & Monitoring

Memo of Concern (MOC)

vs.

Corrective Action Plan (CAP)

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Memo of Concern (MOC)

- A document that outlines identified concerns, deficiencies, and applicable citations. It serves to inform providers of areas needing improvement and requires them to independently identify and implement strategies to address and prevent these deficiencies. The memo acts as a notification, highlighting areas where corrective action is necessary to maintain compliance and quality standards.

The MOC will be sent to the AHCCCS registered provider using their official correspondence contact email on record.

The evidence for each deficiency and its respective citation or allegation, identified through quality-of-care onsite inspections and/or record reviews, will be clearly listed.

Provider Responsibilities Upon Receipt of MOC

1. Confirm receipt of the MOC via email to DFSMQualityAssurance@azahcccs.gov by the specified deadline.

2. Even though a formal Corrective Action Plan is not requested at this time, providers must independently identify strategies to address and prevent future deficiencies.

3. Include intended strategies for addressing and preventing the outlined issues.

4. Indicate who will be responsible for rectifying the deficiencies.

Corrective Action Plan (CAP)

- A formal, written improvement plan required to address and resolve deficiencies. It identifies the root causes of the issues, outlines specific goals and objectives, details the actions to be taken, and specifies the methodologies and staff responsible for implementation within established timelines. The CAP ensures prompt corrections to maintain quality and program integrity, with follow-up and monitoring to prevent recurrence.

The CAP will be sent to the AHCCCS registered provider using their official correspondence address on record and ***delivered via certified mail.***

The evidence for each deficiency and its citation will be listed, along with required actions and submission deadlines for compliance.

Provider Responsibilities Upon Receipt of CAP

1. Confirm receipt and formally accept the CAP via email to DFSMQualityAssurance@azahcccs.gov by the specified deadline.

   * Failure to acknowledge and agree to the CAP within **5 business days** of receipt may result in a notice of termination.

2. The CAP outlines specific, measurable actions to address the identified issues.

3. Monitoring and evaluation should occur, at a minimum, on a quarterly basis to ensure ongoing compliance and improvement.

4. Indicate who will be responsible for rectifying the deficiencies.

5. Immediately start taking the necessary actions to come into compliance.

- 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
- 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
- Sign up for Claims Clues Newsletter, Email Alerts, and Training
- State Exclusion List
- Report Fraud, Waste and Abuse


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

Questions?

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Thank you!

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