Chapter 6000 Administrative Operations

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6001-A CONFIDENTIALITY

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REFERENCES: A.R.S. §§ 36-568(01), 36-551(07), 41-1346, 41-1959, 36-568(01), and, 36-551(01); A.A.C. R6-6-102, et seq., and, R6-6-102.

Confidential Information

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) adheres to statutory, administrative rule, and Departmental requirements that all personally identifiable information obtained, and records prepared during the course of application and provision of services concerning any applicant, claimant, recipient, employer or member is to be considered confidential and privileged, unless otherwise provided by law.

This confidentiality includes members or persons involved in dependency actions, case closure of parental right actions or in any protective services action.

Confidentiality Officer

Each District Program Manager (DPM) must designate, in writing, a person as confidentiality officer and provide the name of the designee to the Assistant Director and District staff. The confidentiality officer shall completely administer and supervise the use of all personally identifiable information including storage, disclosure, retention, and destruction of this information in accordance with departmental procedures of the DES and the Department of Library, Archives and Public Records.

Confidentiality officers or their designee(s) must ensure that members/responsible persons are notified of their rights of confidentiality regarding the disclosure of personally identifiable information such as name, Social Security Number (SSN), ASSISTS or Arizona Health Care Costs Containment System (AHCCCS) I.D. This notification must occur at the time of eligibility closure and during subsequent Individual Support Plans (ISPs). Rights of confidentiality include:

A. The right to inspect/review their own records without unnecessary delay (within 45 days) with the understanding that they may not be denied access to such records;

B. The right to be informed of the procedures for inspecting, reviewing, and obtaining copies of their records;

C. The right to receive one copy of their medical record free of charge annually;

D. The right to be informed of a description of circumstances whereby, for legitimate cause, the agency may deny a request for copies of a case record, even though the record may be reviewed;

E. The right to a listing of types and locations of records maintained and the titles/addresses of the officials responsible for such records;

F. The right to a policy regarding written consent for release of information shall insure that personally identifiable information shall not be released outside the DES/DDD without the written and dated consent of the responsible person except as required by federal law, State statute, court order, or in the event that the health or safety of the member is in jeopardy;

G. Subpoenas are not court orders. Notify the Office of Compliance and Review (OCR) immediately upon receipt of a subpoena for records and forward the subpoena to that office via interoffice mail to Site Code 016F;

H. The right to file complaints;

I. The right to seek correction of records; and

J. Should the agency refuse to amend the records, the member or the responsible person shall have the right to a hearing. Should the hearing find favor with the agency, the member or the responsible person shall have the right to insert in the record a statement or explanation.

Consent forms must be time limited and maintained in the central case record. Those consent forms taken during intake expire in 90 days. Subsequent releases are valid for only up to six months. The person signing the consent must have the capacity to understand the nature of the consent. The consent must be voluntary and signed without coercion.

6001-B RELEASE OF INFORMATION

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REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-104; 42 CFR 483.410(c) (3).

An authorized list of persons or titles, who may have access to personally identifiable information, shall be maintained and available for public inspection. Consents for the release of personally identifiable information, must be:

A. Obtained from the member or responsible person in writing and dated); and,

B. Maintained in the case file.

Consents for the release of information, obtained during intake, expire within ninety (90) days. Subsequent consents should be obtained on an as-needed basis, and are valid for no more than six (6) months.

6001-C ACCESS TO PERSONALLY IDENTIFIABLE INFORMATION

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REFERENCES: A.A.C. R6-6-103.

A *Record of Access* documents all requests for receipt and review of confidential information. The confidentiality officer is responsible for assuring that a *Record of Access* is maintained for each member in service. Requests for information by other State agencies, local or State officials, organizations conducting approved studies, advocacy groups or accrediting organizations will be honored, with ALL personally identifying information deleted.

While Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) do not require a standardized *Record of Access*, all *Record of Access* documents shall include:

A. Requestor's name;

B. Date information copied/sent;

C. Purpose for request;

D. Specific information released;

E. Where information was sent; and

F. Verification of consent.

A *Record of Access* is not required for the following:

A. Member/responsible person or their written designee;

B. Federally authorized members including AHCCCS and DHS staff; or

C. Direct care staff, Qualified Intellectual Disabilities Professional (QIDP)s or Support Coordinators in the performance of their job duties.

The confidentiality officer must maintain a Log Book which documents the names of persons, other than Support Coordinators, or supervisors reviewing the case record and date/time of the review is maintained. The *Record of Access* is typically maintained in the central case record, but may be kept in a location other than the member's master file. In such instances, the Support Coordinator shall document in the master file the required information recorded on the *Record of Access* (See Master Folder Access Log).

6001-D LAWFUL DISCLOSURE OF CONFIDENTIAL INFORMATION

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REFERENCES: A.R.S. §§ 8-105, 11-2, 36-29, 36-568(01).

Confidential information shall not be released by any Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) or contract provider staff except as defined below:

A. When the responsible person designates in writing to whom records/information may be disclosed;

B. Pursuant to court order;

C. To the extent necessary to make claims on behalf of a member for public/private assistance, insurance, or health or medical assistance to which the member may be entitled;

D. In oral/written communications between professional persons in the provision of services or the referral to services;

E. When disclosure of otherwise confidential information is necessary to protect against a clear and substantial risk of imminent or serious injury to a member;

F. To the superior court when a petition to establish guardianship for the person is filed;

G. To other State agencies or bodies for official purposes. All information shall be released without the designation of the name of the member, unless such name is required by the requestor for official purposes. The State agency or body receiving such information shall regard the information as confidential and shall not release it unless a consent to release information has been obtained from the member/responsibility person;

H. To foster parents and/or persons certified to adopt if necessary to assist in the placement with or care of a child(ren) by such persons;

I. To an officer of the superior court, the Department, or any agency required to perform an investigation, if the information is pertinent to the investigation. All information received by the officer, the department or agency pursuant to this paragraph may be disclosed to the court but shall otherwise be maintained as confidential; and,

J. A standing committee of the legislature, a committee appointed by the President of the Senate, or the Speaker of the House of Representatives may obtain the information upon written notification to the director.

Any receiver of confidential information is prohibited from using/releasing the information except in the performance of his/her duties, as defined by statute. Any questions should be referred to the Office of Compliance and Review (OCR).

6001-E VIOLATIONS AND PENALTIES

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EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-204

ANY EMPLOYEE WHO UNLAWFULLY DISCLOSES PERSONALLY IDENTIFIABLE INFORMATION IS SUBJECT TO DISCIPLINARY ACTION OR DISMISSAL. KNOWN VIOLATIONS MUST BE REPORTED TO THE EMPLOYEE'S IMMEDIATE SUPERVISOR AND THE CONFIDENTIALITY OFFICER. VIOLATIONS ARE SUBJECT TO PENALTIES APPLIED BY STATUTE.

6001-F CASE RECORDS

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R6-6-202(B), R6-6-110(B)(8)(9), R6-6-114(14); 42 CFR 483.410(c)(1)(6).

Central Case Records

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), maintains a central (main) case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to an member, and is kept in a location designated by the local confidentiality officer/designee, but usually in the Support Coordinator/QIDP's office. Main case records are available to the member or responsible person upon request, verbally or written.

The Support Coordinator is responsible for making sure that all information generated regarding services to the member, is documented in the central case record. Central case records are required to contain the following:

A. A copy of the member's ISP/Individual Education Plan (IEP);

B. Program data and progress notes;

C. The member's identifying information and a brief social history;

D. Pertinent health/medical information;

E. Current evaluative data/assessments;

F. Authorization for emergency care, if appropriate;

G. Visitation records, if appropriate;

H. Record of financial disbursements, if appropriate;

I. Active treatment schedule (ICF/IID);

J. Resident fact sheet, if appropriate;

K. Periodic dental records, if appropriate;

L. ICAP, if appropriate;

M. Documentation regarding the protection of member rights;

N. An accepted diagnosis/diagnostic scheme;

O. Documentation of an evaluation that identifies the member's specific needs;

P. Reviews/modifications to the ISP/IFSP/IEP;

Q. Communication among persons involved with the member and his/her program;

R. Documentation of protection of the legal rights of each person served, staff the Department, or contract providers by recording all actions that may significantly affect these rights;

S. Documentation to furnish a basis of review, study and evaluation of overall programs provided by DES/DDD;

T. Member primary data from ASSISTS; and,

U. For members residing in a Nursing Facility (NF) placed on termination status, a Primary Care Physician (PCP) statement that the NF does or does not continue to meet the member's needs, documentation of the member's choice of placement and the reason for non-placement in a NF placed on termination status for a new placement.

Case records, where applicable, shall contain the following additional documentation:

A. Of Arizona Long Term Care System (ALTCS) eligibility;

B. Utilization review report;

C. Current photograph of the member;

D. Physician's statement of need;

E. Pre-Admission Screening;

F. Psychological evaluations/social history;

G. Medication history;

H. Immunization record;

I. Incident, injury, illness and treatment reports including hospital stays;

J. Seizure reports;

K. Records of contacts/referrals, etc.;

L. An accounting ledger;

M. Authorization for emergency care;

N. Behavioral health records as described in this Policy Manual; and

O. Other pertinent information.

Program/Service Records

Occasionally the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records. The Confidentiality Officer, Support Coordinator or QIDP is responsible for assuring that files are available at each site where the member receives services, as appropriate, that the Support Coordinator/QIDP has access to such files, and that a summary of information contained in such records is entered into the member's main record. These files shall also contain:

A. The name/address and phone number of the physician or health facility providing medical care;

B. Reports of accidents, illness, and treatments;

C. Reports of significant behavioral incidents;

D. Current medication treatment plan;

E. A description of the member's specialized needs;

F. A copy of the ISP/IEP;

G. Program data/progress notes;

H. Identifying information/social summary;

I. Pertinent health/medical information;

J. Current evaluative data/assessments;

K. Authorization for emergency care;

L. Visitation records;

M. Records of financial disbursements;

N. Active treatment schedule (ICF/IID);

O. Resident fact sheet; and where applicable

P. Periodic dental reports.

Each member's case record must include current consents. A medical consent signed by the member or the responsible person shall be required in the event of emergency medical care, routine medical care, and special procedures.

6001-G DOCUMENTATION REQUIREMENTS

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EFFECTIVE DATE: July 31, 1993

All documentation entered into a case record must be in ink or typed, legibly written in non-technical terminology if possible, and dated, and signed by the person making the entry. In case of an error in documentation, cross out the error with a single line and initial it. Do not erase or use "White Out". If room remains on a Progress Note page, draw a line through the remaining spaces after your signature. Each case record shall include a legend for explaining symbols, and abbreviations.

The Support Coordinator has primary responsibility for assuring that case records contain all of the required documentation, and that such documentation meets the criteria set forth in this Chapter by being complete, accurate, timely, and reflective of the member's programmatic, social, medical, developmental, educational, or vocational status.

6001-H RECORDS STORAGE AND SECURITY

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REFERENCES: A.R.S. § 12-2297.

Internal

Case records for members currently eligible for services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) are considered active records. Active files may contain too much information to be confined to one case record. Overflow files may be established, and utilized to store non-essential, out-dated information.

Once established, overflow files are considered inactive, and can contain progress notes, Individual Support Plans (ISP), correspondence, status reports, guardianship records, medical records, etc. The Support Coordinator, Qualified Intellectual Disabilities Professional (QIDP), or the Confidentiality Officer must note in the most current active record that there is an overflow(s) file, and indicate where it is stored.

Although these case records can be maintained within DES/DDD in a place designated by the confidentiality officer for a period of time, the Support Coordinator/QIDP should coordinate the transfer of overflow/inactive files to the State of Arizona Records Management Center (813Z), for storage and retention. See this chapter for procedural information.

External

The Records Center is the DES official depository for inactive case records. The Records Center provides storage, retrieval and re-file services for DES.

To transfer inactive files for storage/retention, staff must:

A. Review the records retention schedule to determine that the records are appropriate for retention at this time;

B. Pack records into standard boxes 15” L X 12” W X 10” H leaving a minimum of two (2) inches of space to permit retrieval;

C. Complete a J-239, *DES Records Storage Transmittal (Appendix 1800.C)*, and forward it to the DES Records Center at 813Z;

D. Assign a temporary box number to each box and place that number on the small side of the box, but not directly below the handles. The temporary numbers must be consecutive and continue in consecutive order for future pick-up; and,

E. Upon receipt of a Records Center box number, place that number directly below the handle.

Records Retrieval

To retrieve stored records, complete a J-240, *Records Reference Request* and send it to DES Records Center at 813Z.

Destruction of Records

Records will be destroyed in accordance with the records retention schedule in compliance with A.R.S. § 12-2297.

6001-I MANAGEMENT AND MAINTENANCE OF RECORDS RELATED TO THE MEDICAID LINE OF BUSINESS

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EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297; 45 CFR 164.530(j)(2).

The Division will maintain all records for a period of five years from the date of final payment under contract with Arizona Health Care Cost Containment System (AHCCCS) unless a longer period of time is required by law.

For retention of the member's medical records, the Division will ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider shall retain the member's medical records according to the following:

A. If the member is an adult, the Division will retain the member's medical records for at least six years after the last date the adult member received medical or health care services from the Division.

B. If the member is under 18 years of age, the Division will maintain the member's medical records either for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the Division, whichever date occurs later.

The Division will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j) (2).

If the Division's contract with AHCCCS is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the Division's contract with AHCCCS, or costs and expenses of the Division's contract with AHCCCS to which exception has been taken by AHCCCS, shall be retained by the Division for a period of five years after the date of final disposition or resolution thereof.

6002-A DEFINITIONS OF INCIDENTS AND SERIOUS INCIDENTS

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EFFECTIVE DATE: July 31, 1993

An Incident is defined as an occurrence, which could potentially affect the health and well-being of a member enrolled with the Division or poses a risk to the community. If the incident is determined to be "serious" as defined in this policy, the "Serious Incident" section of this policy shall be followed.

Incidents

Incidents include, but are not limited to:

A. Death of member;

B. Potentially dangerous situations due to neglect of the member;

C. Allegations of sexual, physical, programmatic, verbal/emotional abuse;

D. Suicide threats and attempts;

E. Member missing;

F. Accidental injuries which may or may not result in medical intervention;

G. Violation of a member's rights as stated in this policy manual;

H. Provider and/or member fraud;

I. Complaints about a community residential setting, resident or the qualified vendor;

J. Allegations of inappropriate sexual behavior;

K. Theft or loss of member's money or property;

L. Use of emergency measures;

M. Medication errors such as:

1. Wastage of a Class II substance;

2. Giving medication to the wrong member;

3. Wrong method of medication administration;

4. Wrong dosage administered; or,

5. Missed medications;

N. Community disturbances in which the member or the public may have been placed at risk;

O. Serious work related illnesses or injuries (Division employees). (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee] ;)

P. Threats to Division employees or state property (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee]); and accidents on state property involving non-member/non-employees. (See DES Policy # DES 1-07-02B, Unusual Incident Reporting [Client] ;)

Q. Environmental circumstances which pose a threat to health, safety or welfare of members such as loss of air conditioning, loss of water or loss of electricity;

R. Unplanned hospitalization or emergency room visit in response to an illness, injury, medication error;

S. Unusual weather conditions or other disasters resulting in an emergency change of operations; or,

T. Provider drug use.

Serious Incidents

A Serious Incident is an extraordinary event involving a member, facility, or employed/contracted worker. A serious incident poses the threat of immediate death or severe injury to a person, substantial damage to individual or state property, and/or widespread interest in the news media.
Serious incidents include, but are not limited to the following:

A. All deaths;

B. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a member or staff member;

C. Severe physical injury that:

1. Creates a reasonable risk of death;

2. Causes serious or permanent disfigurement: or,

3. Causes serious impairment of a member's or worker's health;

D. Property damage estimated in excess of $10,000;

E. Theft or loss of a member's money or property of more than $1,000;

F. Reporting to law enforcement officials because a Division enrolled member is missing and presumed to be in imminent danger;

G. Reporting to law enforcement officials due to possession and/or use of illegal substances by members or staff/providers;

H. A 9-1-1 call due to a suicide attempt by a member; or,

I. An incident or complaint from the community that could be or is reported by the media.

6002-B INCIDENT MANAGEMENT SYSTEM (IMS) DEFINITIONS

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The following definitions are used when entering incidents into the Incident Management System (IMS) database. Incidents are entered by the type which is the main reason for the incident and category which is the main classification for the incident.

A. *Accidental Injury:* a non-intentional or unexpected injury.

B. *Member Missing:* an incident in which a member without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in his/her Planning Document is missing longer than the plan provides.

C. *Community Complaint*: a complaint from the community that puts a member or the community at risk of harm.

D. *Death*: "expected" (natural), "unexpected" (unnatural) or "no provider present".

1. *Expected deaths*: may include deaths from long-standing, progressive medical conditions, or age-related conditions, e.g. end-stage cancers, end-stage kidney or liver disease, HIV/AIDS, end-stage Alzheimer's/Parkinson's Disease, severe congenital malformations that have never been stabilized.

2. *Unexpected deaths*: include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma/abuse, sudden deaths from undiagnosed conditions, or generic medical conditions, (i.e. seizures, pneumonia, falls) that progress to rapid deterioration.

3. *No provider present:* refers to deaths of members living independently or with family and no provider is present at the time of the death. The "expected" or "unexpected" categories shall be used if a provider is present at the time of death.

E. *Emergency Measure*: the use of physical management techniques (Client Intervention Techniques [CIT] level II) or behavior modifying medications in an emergency to manage a sudden, intense or out of control behavior.

F. *Fact-finding*: a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident. The process could include: interviews with the member; Provider and/or Division staff; collection and/or review of member and provider documentation; and coordination with investigatory agencies.

G. *Human Rights Violation*: a violation of a member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the State of Arizona. Human rights are defined in A.R.S § 36.551.01. as a violation of a member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat.

H. *Member*: a person enrolled with the Division of Developmental Disabilities.

I. *Investigation*: collection of facts/information for the purpose of describing and explaining an incident. An investigation may be completed by law enforcement, Child Protective Services, Adult Protective Services, or other state agencies.

J. *Legal*: an incident of alleged provider fraud/inappropriate billing, member exploitation through using a member to gain monetary or personal rewards, the possession or use of illegal drugs by provider or state staff.

K. *Medication Error*: the administration of medication in an incorrect manner. This includes: giving medication to the wrong member, administering medication in the wrong method, giving the wrong dosage, or not administering the medication.

L. *Neglect*: a pattern of conduct resulting in a deprivation of food, water, medication, medical services, shelter, or other services necessary to maintain physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty, or failure to carry out a prescribed treatment plan.

For example: in the case of children, the definition includes the substantial risk of harm due to inability or unwillingness of a parent, guardian or custodian to care for the child. This includes; supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

M. *Other:* incidents which involve behavioral episodes without the use of physical restraints, hospitalizations or treatment at an emergency medical facility/urgent care facility due to medical conditions or illness.

Other Abuse: programmatic abuse, verbal/emotional abuse and sexual abuse.

1. *Programmatic Abuse:* aversive stimuli techniques not approved as part of a person's plan. This can include isolation, restraints, or not following an approved plan and/or treatment strategy.

2. *Verbal/Emotional Abuse:* remarks or actions directed at a member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory, or profane.

3. *Sexual Abuse:* any inappropriate interactions of a sexual nature toward or

solicited from a member with developmental disabilities.

N. *Physical Abuse*: intentional infliction of pain or injury to a member.

O. *Property Damage/Theft*: damage or theft of state property in a member-related incident, or the theft or damage of a member's property.

P. *Provider*: any person, entity or person hired by the entity, who is paid, through contract or agreement to deliver services to any member.

Q. *Suicide*:

1. Attempted suicide with medical and/or police involvement; or,

2. Threatened suicide with a statement from a member that they want to commit suicide.

R. *A Health Care Acquired Condition (HCAC) inclusive of the Hospital Acquired Condition (HAC):* as described under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.

1. Foreign object retained after surgery;

2. Air embolism;

3. Blood incompatibility;

4. Pressure ulcers stage III and IV;

5. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burn, electric shock);

6. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity);

7. Catheter associated urinary tract infections (UTI);

8. Vascular catheter-associated infection;

9. Surgical site infection following: after coronary artery bypass surgery (CABG), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery) and orthopedic procedures (spine, neck, shoulder and elbow);

10. Deep venous thrombosis or pulmonary embolism (DVT/PE) after total knee or hip replacement (does not include pediatric and obstetric patients);or,

11. Other Provider Preventable Conditions (OPPC) means a condition occurring in the inpatient and outpatient health care setting which Arizona Health Care Cost Containment (AHCCCS) has limited to the following;

    a. Surgery on the wrong member;

    b. Wrong surgery on a member; and,

    c. Wrong site surgery.

6002-C REPORTING REQUIREMENTS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

When an incident occurs, take whatever actions are necessary to resolve the emergency and implement protective measures immediately for the person's safety, which may include calling 9-1-1 or taking other emergency action.

A. As designated by law, medical professionals, psychologists, social workers, support coordinators, peace officers, and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters.

   Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred are required to report such information immediately to a peace officer or protection services worker, (i.e., Adult/Department of Child Safety, Tribal Social Services.) Refer to Support Coordination and Incident Reporting in this Policy Manual for additional information regarding mandated reporting.

B. Serious Incidents, as described in this chapter, are to be reported and written as soon as possible, but no later than 24 hours after the incident.

   Within 24 hours of a serious incident, the following actions must be taken:

   1. The provider shall notify the District of the serious incident;

   2. District personnel must enter the incident into the Incident Management System (IMS) database within 24 hours or the next business day if the incident occurs over a weekend or holiday;

   3. Notification to Responsible Person, i.e., guardian or family member - The responsible person shall be notified unless otherwise specified in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan). The procedures for notification of the responsible person shall be coordinated between the service provider and the Support Coordinator. The Support Coordinator or designated District staff member shall ensure notification of the responsible person of an incident within 24 hours after the incident. The responsible person shall also be notified of any follow up actions that occurs.

C. All other incidents listed in the definitions section of this policy must be reported to the District by close of the next business day following the incident, and be entered by designated District personnel into the IMS database within 48 hours of notification (if applicable).

D. Incidents occurring after normal business hours must meet the above reporting requirements.

6002-D MEMBERS AT-RISK IF MISSING

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EFFECTIVE DATE: July 31, 1993

The actions in this section are required when a vulnerable member leaves a Division funded setting without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in their Planning Document is missing longer than the plan provides.

A vulnerable member is defined as a person who is at potential risk of harm while unsupervised in the community. He or she may be a danger to self or others require medication to control a condition such as diabetes, seizure disorder, or lack essential survival skills (such as the ability to communicate or move safely about the community). The Individual Support Plan team shall assess the potential risk of a member who may leave his or her service site without supervision and shall note the results of that assessment in the Individual Support Plan. If the member has prescribed medication, the Team shall contact the primary care physician and/or psychiatrist to determine if a potential medical risk may arise if the member goes without prescribed medication for any length of time; this shall be noted in the plan.

Provider Responsibilities:

A. When a vulnerable member leaves a Division funded setting without planned alone time is missing and is at-risk of harm, or when a member with alone time as defined in their Planning Document is missing longer than the plan provides, the provider staff will:

1. Conduct a search of the immediate area,

2. If the member is not located within 15 minutes, provider staff will notify the program supervisor/other staff to assist with the search,

3. If the member is not found within thirty minutes, the provider must notify law enforcement agencies (e.g., Police, Sheriff's Office) in both the immediate and surrounding communities and the parent/guardian,

4. To assist in locating the member, also contact the following entities during the search: hospitals, shelters, jails and bus stations,

5. If the member is not located within one hour, the provider must notify the Division by speaking directly to Support Coordination staff during regular business hours or by calling the District after hours reporting system on evenings and weekends, or

6. The provider will report the following information to the Division and submit a written incident report within 24 hours:

   a. Age of member,

b. General description of the person,

c. Time and location of disappearance,

d. Efforts to locate member,

e. Vulnerability,

f. Means of communication,

g. Medical or special needs,

h. Precursors to disappearance,

i. Time police and parents/guardian notified,

j. Other entities contacted, and

k. Legal status (e.g., foster care, probation).

B. If the member is located within one hour, the provider will notify the parent/guardian immediately and provide notification to the Division within 24 hours.

Media Involvement

The decision to contact the media for assistance in locating a member will be a collaborative agreement between the Division, law enforcement officials, the parent/guardian and the provider.

A. Prior to contact with the media, the provider will obtain verbal or written authorization from the parent/guardian. The approval must be documented in the provider and the Division records.

B. As authorized, the provider will work directly with law enforcement officials by providing essential information about the member to be released to the media. Law enforcement will make the request for release of the vulnerable member's information to the media.

C. Support Coordination will immediately notify the District's Program Manager or designee when a media release is requested.

D. District Program Manager/designee will notify the Division's Assistant Director or designee for notification to the Department's Director and Public Information Officer.

Planning Team Responsibilities

The member's Planning Team will meet to discuss the incident within 30 days or as designated in the Behavior Plan to review the appropriateness of the current plan and Risk Assessment Tool.

6002-E INCIDENT REPORTS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

The Incident Management System (IMS) is the computerized database for incidents and reports.

A. All incidents meeting the criteria of the IMS including serious incidents must be entered into the IMS as defined in this policy.

B. Reporting an incident

1. Provider's may use the Division's *Incident Report* Form to report incidents, or,

2. A provider's own internal incident report form may be used to record incidents as defined in this policy.

C. Incident Reports shall:

1. Be written clearly, objectively, and in order of occurrence without reference to the writer's opinion. Incident reports may be available to family/guardians and are considered legal documentation.

2. Include demographic information (i.e., full name, address, date of birth and Focus ID number) about the member.

3. Include the names and job titles of staff that witnessed or were involved in the alleged incident.

4. Include a description of the incident including all known facts, location, and the date and time the incident occurred.

5. Include causes of injury (if applicable).

6. State whether the responsible person was notified and, if not, why.

7. Include whether or not law enforcement, Adult/Department of Child Safety or Tribal Social Services were contacted.

8. Include signatures and names of the person completing the report and his/her supervisor and any additional comments.

9. Be completed for each individual involved in the incident and reference other individuals by initials only.

10. Be included in the member's primary record maintained by the Support Coordinator and by the provider completing the report.

6002-F FACT FINDING

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 31, 1993

The Division may initiate a fact-find of any incident. Except when such action would compromise the legal investigation by law enforcement, Protective Services, or another State Agency (i.e., DES Office of Licensure, Certification, and Regulation, an Office of the Inspector General (OIG)) the Division should notify the service provider of the onset of a fact find.

Service providers shall ensure that any service provider worker alleged to have endangered the health or safety of an individual shall not have direct contact with any individual served by the Division, pending the outcome of the Division's fact finding activities.

Division staff is responsible for notifying and assigning appropriate personnel to initiate fact-finding.

The District Program Manager is responsible to assign only qualified Division personnel to complete a fact-finding. Division personnel assigned to conduct a fact finding will meet the following qualifications:

A. Have demonstrated ability to be objective;

B. Can maintain confidentiality;

C. Can complete the task within the assigned period;

D. Have expertise regarding the particular situation; and,

E. Have no conflict of interest involving the situation.

The staff assigned to complete fact finding of any incident must have successfully completed fact-finding training offered by the Division.

When a fact-finding of an incident occurs, the following apply:

A. Protective measures must be taken immediately for the person’s safety.

B. Initiation of the fact-finding occurs within 24 hours of notification or the next business day for the following incidents:

   1. Allegations of physical abuse which results in medical treatment or police involvement;

   2. Allegations of sexual abuse;

   3. High risk incidents of member missing;

4. Attempted suicide;

5. Unexpected deaths;

6. Allegations of neglect that involve imminent danger; or,

7. Accidental injuries involving hospitalization.

C. Fact-Findings are initiated within 10 days of notification for:

1. Allegations of physical abuse which do not result in medical/police intervention;

2. Allegations of verbal/emotional or programmatic abuse;

3. Community complaints;

4. State property damage or theft above $100;

5. Member property damage or theft over $25;

6. Expected deaths;

7. Allegations of human rights violations;

8. Allegations of neglect that involve potential danger;

9. Accidental injuries that resulted in medical intervention; or,

10. Legal issues involving allegations of fraud, member exploitation, or provider drug use.

The fact-finding may involve a review of the provider's incident reports, as well as a review of other records maintained in the provision of services. A fact-finding will typically include interviewing the person reporting the incident, the service provider, and/or members who might have additional information or insight regarding the incident.
If an external investigation is initiated, the Division may delay its fact-finding until Office of Special Investigations, Department of Child Safety (DCS), Adult Protective Services, Tribal Social Services, law enforcement personnel, or other State Agencies (e.g.,: DES Office of Licensing Certification and Regulation [OLCR], OIG) have completed their investigation, to avoid potential conflicts. If another state agency is involved, the assigned Division employee must coordinate efforts with that agency.

Conclusion of the Division's fact-finding shall be within 30 days from notification date of the incident. A fact-finding can be extended an additional 30 days twice for a total of 90 days if more time is needed to allow DCS, Adult Protective Services, Tribal Social Services, law enforcement or, other state agencies to complete their investigation and provide the results to the Division.

6002-G ABUSE AND NEGLECT

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-561(B), 13-3620, 46-454, 46-451.

Definitions

Abuse:

A. Intentional infliction of physical harm;

B. Injury caused by negligent acts or omissions;

C. Unreasonable confinement or unlawful imprisonment; or,

D. Sexual abuse or sexual assault.

Abusive treatment:

A. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or any sexual abuses;

B. Emotional abuse which includes ridiculing or demeaning a member, making derogatory remarks to an member or cursing directed towards an member; or,

C. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Individual Support Plan (ISP) and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

Child, youth or juvenile: a member who is under the age of eighteen years.

Exploitation: the illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Incapacity: an impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.
Neglect: a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health. Neglect also means:

A. Intentional lack of attention to physical needs of members such as toileting, bathing, meals, and safety;

B. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse;

C. Sleeping on duty or abandoning work station; or,

D. Intentional failure to carry out a prescribed treatment plan for a member.

Physical injury: the impairment of physical condition includes, but shall not be limited to any skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

Serious physical injury: physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, serious impairment of health or loss, or protracted impairment of the function of any bodily organ or limb.

Vulnerable adult: a member who is eighteen years of age or older who is unable to protect himself/herself from abuse, neglect, or exploitation by others because of a mental or physical impairment.

Department of Child Safety

When a Support Coordinator suspects abuse or neglect, as a mandated reporter, the Support Coordinator must immediately report to Department of Child Safety (DCS). Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator shall cooperate during investigations, and follow-up as required.

Reports made regarding American Indians will be in accordance with tribal procedures.

Reports

Reports made to DCS shall contain:

A. The names, and addresses of the minor and his/her parents or person or persons having custody of such minor;

B. The minor's age, and the nature, and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect; and,

C. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

A copy of the *Incident Report*, and the *Child Abuse Reporting* Form will be forwarded to the DCS Hotline within 24 hours.

Incident Report

When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator shall complete an Incident Report (IR) in the Incident Management System. The District will ensure the DCS Program Manager receives an information copy of all IRs on DCS referrals from Division staff.

When DCS staff reports alleged abuse or neglect made by someone other than Division staff, the Support Coordinator will complete and forward an IR.

Investigative Procedures

It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. The Support Coordinator shall receive the results of the investigative decision by DCS. If, subsequent to an investigation, DCS opens a case, the Support Coordinator shall participate in a team staffing to develop a collaborative plan.

Working with Department of Child Safety

The Support Coordinator shall work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

Whenever possible, the Support Coordinator shall meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.
The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

Adult Protective Services

In accordance with A.R.S. §46-454, as a mandated reporter, the Support Coordinator or other Division staff shall immediately report any suspicions/allegations of abuse, neglect or exploitation of an adult to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements the person:

A. Is 18 years of age or older; and,

B. Is a vulnerable adult as defined in A.R.S. § 46-451.

Reports

Reports made to APS shall contain:

A. The names and addresses of the adult and any persons having control or custody of the adult, if known;

B. The adult's age, and the nature, and extent of his/her incapacity or vulnerability;

C. The nature, and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and,

D. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

A written follow-up report shall be mailed or delivered to the police officer or local adult protective services worker within 48 hours or on the next working day if the 48 hours expire on a weekend or holiday.

When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together with the Support Coordinator or other Division staff as appropriate. Specific responsibilities are decided on a case-by-case basis. The APS worker will remain involved until the abuse or problem situation has been resolved.

When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS, and notification of the fact finding process. DES/DDD staff, as appropriate, will conduct a fact- find to determine program, and contract compliance issues.

Incident Report

When a report is made to Adult Protective Services, the Support Coordinator shall complete an Incident Report (IR), following procedures established in this policy manual.

Working with Adult Protective Service

The Support Coordinator shall work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

Whenever possible, the Support Coordinator shall meet in person with the APS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly, and satisfactorily resolved at the Support Coordination level. The Support Coordinator shall cooperate during investigations, and follow-up as required. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

6002-H REFERRAL TO OTHER INVESTIGATIVE AGENCIES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

The Assistant Director or the Office of Compliance and Review may refer incidents for investigation to the Department of Economic Security (DES) Office of Special Investigations. An external investigation request may be made for incidents involving:

A. Potential criminal activity;

B. Possible misconduct by a Division or service provider's employee; or,

C. Fraud (this type of incident will also be referred to Arizona Health Care Cost Containment System (AHCCCS), as appropriate).

6002-I INCIDENT CLOSURE AND CORRECTIVE ACTIONS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

A. An incident is complete when:

1. The fact finding if needed is reviewed and approved by the Division;

2. Recommendations for corrective action are identified and provided to appropriate Division and provider personnel;

3. Corrective action plans, if needed, are requested, and received from the provider and approved by the Division; or,

4. Designated District personnel have verified the information entered into the Incident Management System (IMS) database and have verified that all corrective actions have been completed no later than 60 days from the acceptance of for a plan.

B. Corrective actions may be member-specific or systemic.

An example of a member-specific corrective action would be requiring the person's Planning Team to reconvene to discuss the incident and review the need for any changes in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan) to ensure the health and safety of the member.

Systemic corrective actions may require the provider to rewrite or clarify agency policy, procedure, recommend specialized training of staff, or require other quality improvement actions to increase the ability of the provider to improve the health and well-being of members served.

C. The member's Planning Team shall review all incidents for the effectiveness of services and assess risk as part of the Planning Document and update the process.

D. The Division's Program Monitoring staff (at the Central Office and District Level) shall review all incidents for residential placements and Day Treatment & Training programs to be monitored prior to the visit to identify any areas that may warrant extra monitoring.

6002-J TRENDING FOR QUALITY IMPROVEMENT

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Trending is an essential component of the Incident Management System (IMS).

District Quality Management lead will compile District specific quarterly data analysis reports and submit to the Quality Management unit. The content will include at a minimum:

A. Total incidents by type and category, provider and member;

B. Trends by provider and member including:

1. Total allegations of abuse, neglect, and exploitation, and,

2. Information of whether or not the allegation was substantiated; and,

C. A narrative analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.

The Division's Central Office designee will prepare a Statewide Incident Summary Report monthly and annually and will include at a minimum:

A. Total incidents by type and category by district;

B. Trends by provider and member including:

1. Total allegations of abuse, neglect and exploitation;

2. Information of whether or not the allegation was substantiated.

C. In a narrative format an analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.

Incident Summary Reports will be provided to the Quality Administrator, the Assistant Director and to designated personnel.

The Division Management Team and Statewide Quality Management Committee will formally review the summary reports on a quarterly basis.

If the District or Statewide Incident Summary Reports indicate any areas of concerns or patterns, focus studies will be completed by the Central Office designee, District Quality Management leads or designee. If the focus study confirms any areas of concerns or patterns, corrective actions will be recommended for quality improvement.

6002-K INFORMATION SHARING

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Incident reports may be made available to:

A. The Human Rights Committees as prescribed in this policy manual;

B. The member/responsible person(s);

C. Others who are bound by confidentiality on a need to know basis; and, or,

D. All requests should be directed to the Office of Compliance and Review.

Fact finding reports and action plans are confidential. Fact-finding and corrective action plans are summarized in the Incident Management System (IMS) Fact Finding screens.

6002-L MORTALITY REVIEW AUDITS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations, and implementation of corrective actions involving the death of a member. Quality reports of the system will also be used to identify patterns of user concerns, i.e., entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance, or management information system change.

6002-M MORTALITY REVIEW PROCESS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 11-597

The purpose of this policy section is to improve quality of care for members by a systematic examination of deaths.

Notification Procedure

When a death is reported to a Support Coordinator, the Support Coordinator will forward the information to their District Quality Unit's Incident Report (IR) Central for entry into the Incident Management System (IMS) database within 48 hours of notification of a death.

Once the Support Coordinator is alerted to an incident, they will notify the responsible person or next of kin, if they have not already been notified. The Quality Assurance Manager or designee will also immediately notify the appropriate District Manager or designee within 24 hours of the Division's notification of a member's death. All service authorizations must be closed in Focus with the date of death as the effective date by the Support Coordinator. Support coordination (Department of Child Safety) and Bereavement Counseling offered to the family may remain authorized after the Division was notified of the death. If staff becomes aware of any service utilization after the date of the member's death, it should be reported into the IMS.

If Health Care Services staff is notified of a death, they will notify the Central Office on-call person within 24 hours.

The District Manager or designee will notify the Assistant Director/designee or the Division's on-call line within 24 hours of being notified of a death, as well as the Adult or Department of Child Safety agency as required by statute. The District Manager or designee will also notify the Human Rights Committee District liaison.

Central Office designees will notify the Department of Administration (DOA) Risk Management if the death may give rise to a liability claim against the state.

Review Procedure

A. District Review

1. All deaths are to be reviewed jointly by the Support Coordinator and his/her supervisor within 30 days, to identify apparent issues relating to care or cause of death.

2. The Support Coordinator or designee will enter the following information, as applicable, relating to the death into the IMS database:

   a. Member's underlying primary medical conditions.

   b. Detailed circumstances of the death Date of Death? What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had the member been ill? Was the member recently seen by PCP? What symptoms of illness did the member have? What is the suspected cause of death (if known)?

   c. Was Hospice involved?

   d. Did the member have an Advance Directive in place?

   e. Had Department of Child Safety/Adult Protective Services (DCS/APS) been involved within the last year?

   f. Is there litigation pending?

   g. Is there further fact-finding pending?

   h. Was the family/guardian notified?

   i. Did the Division offer support/grief counseling for the family?

3. The District will send the primary case file to Central Office Health care Services within 60 days after being notified of the death.

B. Health Care Services Quality Assurance Investigative Nurse (HCS QA Nurse) Review

1. The Health Care Services Quality Assurance (QA) Nurse reviews the mortality information documented in the IMS database and requests further information, as necessary.

2. The Chief Medical Officer assigns the death into one of the following categories:

   Level A These include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division at the time of death.

Level B These include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/9-1-1 calls, decubitis, methicillin-resistant staphylococcus aureus (MRSA), unexpected circumstances, unusual or suspicious circumstances, and problems with emergency or other medical care.

C. The HCS QA Nurse requests death certificates and when indicated, autopsy reports.

D. The HCS QA Nurse gathers additional medical records for review when indicated.

E. The HCS QA Nurse tracks mortality information in a database specifically designed to collect information related to member deaths.

F. The Chief Medical Officer communicates via IMS the status of the mortality review and when the case is considered closed. The Chief Medical Officer shares any recommendations in the summary.

G. Based on the information reviewed by the Chief Medical Officer, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting; the selected cases warrant additional review by the Committee and demonstrate situations where systemic improvement may be made**.**

Mortality Committee Review

A. The Committee shall discuss each case selected and identify changes to practice e, training, or processes that may positively affect care and treatment. The Committee shall report in writing their recommendations to the Management Team.

B. Within 30 days of receiving a recommendation from the Committee, the Management Team shall report their disposition and intended steps to respond to recommendation(s).

C. Following the Mortality Review Committee review, the case shall be closed unless it is referred for Level C review.

Review Level C – Root Cause Analysis Review

A. Root Cause Analysis, which will follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, will be arranged by the Chief Medical Officer and will be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.

B. No more than 3 Root Cause Analyses shall be conducted in a fiscal year.

C. The HCS QA Nurse shall monitor the implementation of recommendations from a Root Cause Analysis.

Process

A. The Mortality Review Committee shall meet at least quarterly.

B. The Chief Medical Officer shall issue annually a Mortality Review and Analysis, which will aggregate, analyze, and summarize mortality data and actions taken for system improvements.

C. The HCS QA Nurse is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.

D. Autopsies should always be requested for children in foster care. For all other deaths, requests should be made whenever it is possible that something can be learned about the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved. A request for an autopsy should follow these steps in priority order:

1. Arizona Revised Statute 11-597 (www.azleg.gov/) provides for County Medical Examiners to complete an autopsy and outlines when this is required.

2. When the Medical Examiner does not identify a need for an autopsy, the Division can request the family to authorize an autopsy, at the expense of the Division, when the Division's Chief Medical Officer believes there are unanswered questions surrounding the death.

3. Autopsy reports will be requested by the HCS QA Nurse.

E. Death Certificates will be requested by the HCS QA Nurse.

F. Reviewers and all others involved with these processes shall in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the member.

6002-N FRAUD AND FALSE CLAIMS

REVISION DATE: 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: ARS §§ 13-1802, 13-2002, 13-2310, 13-2311, 36-2918;
Arizona Administrative Code Title 6, Chapter 6, Articles 8, 10, 11, and 15; 42 CFR 455.2.

Overview

This section defines fraud and describes the procedures for prevention, detection, and reporting of fraud, false claims, and abuse within the Division.

Policy Objectives

The objectives of this policy are to:

A. Prevent or detect fraud and abuse,

B. Delineate reporting requirements,

C. Define investigative procedures,

D. Explain corporate compliance,

E. Describe training requirements, and

F. Specify policy requirements for providers.

Definitions

Abuse - Related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary or which fail to meet professionally recognized standards for health care.

Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

A. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

B. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

C. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

D. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government.

Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

Prevention - Keep something from happening.

Primary Contact - The central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the AHCCCS in the manner prescribed in this policy.

Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division‘s Policy Manual, All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

Remit Advice - A document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

Prevention and Detection

The Division has established internal controls on the member payment system including claim edits and prior authorization requirements. The Division produces reports to review high utilization by members (CLT_0060), underutilization by members (CLT_0150), service cost, and units by service title, month by month over the fiscal year, and other reports for analysis. The Business Operations Unit as outlined below conducts a post-payment review process.

A. Claims Edits

All claims are edited through a computerized system. When a claim is entered in the system for payment the system checks to ensure that a completed authorization is in place. System edits prevent payment for incomplete or absent authorizations and/or duplicate claim submittals.

The Division also segregates the functions of service authorization and claims processing.

B. Post Processing Review of Claims

The Division reviews detailed "remit advices". Additionally, the Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

C. Prior Authorization

All services are prior authorized. Prior authorization occurs within the guidelines set forth in this policy manual and the AHCCCS Medical Policy Manual.

D. Utilization/Quality Management

The Division complies with the requirements set forth in the AHCCCS Medical Policy Manual.

E. Contract Provisions

All providers shall comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement".

F. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended, and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff. Fraud can be reported to the Division by anyone in writing or by phone reports can be made by calling the appropriate District Office. The Office of Compliance and Review can be contacted directly to report fraud as well as by calling 1.866.229.5553 or submitting information to:

Division of Developmental Disabilities
Office of Compliance and Review
1789 W. Jefferson St
Phoenix, AZ 85007

All the Division employees and providers shall comply with this chapter. The Manager of the Division Office of Compliance and Review shall report potential incidents to AHCCCS utilizing the AHCCCS prescribed form.

False Claims Act

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistle blower" is protected under the FCA. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

Any provider receiving at least $5,000,000 in annual payments through the Division; shall establish written policies for all employees regarding Fraud and the FCA requirements.

Corporate Compliance

The Corporate Compliance Officer implements, oversees, and administers the Division's compliance program including fraud and abuse control. The Corporate Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes, and trends fraud and false claims through the monthly Corporate and Quality Data Analysis Committee. The committee includes the Chief Medical Officer, Quality Management Administrator, Quality Assurance staff, Office of Compliance and Review Manager, Resolution Unit, Arizona Long Term Care System (ALTCS) Administrator and Business Operations Administrator. The monthly agenda includes a review of all Incident Management System data for the past month (including suspected fraud); Resolution System data for the past month; Program Monitoring reviews for the past month; claim disputes, appeals, and state fair hearings for the past month; and any other data available, including results from post-payment reviews. The committee will make recommendations for improvement of the compliance program as identified through the analysis and review of reports. The Division's Compliance Unit reports any suspected fraud or false claims incidents to the appropriate AHCCCS entity as required by contract and/or AHCCCS policy.

Training

The Division has available training through both the continuous core curriculum as well as Computer Based Training regarding the FCA. In addition, the Office of Compliance and Review provides on-going standalone training to each District regarding compliance issues including the FCA. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.

6002-O HEALTH CARE ACQUIRED CONDITIONS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Identification and Reporting

Any Health Care Acquired Conditions (HCAC) occurrence that has been identified and verified will be entered into the Division's Information Management System (IMS) by the Health Care Services (HCS) Quality Assurance Registered Nurse/designee who has the final determination of confirmed HCAC occurrence and will enter each confirmed HCAC as an Incident Report (IR) within twenty-four (24) hours of confirmation. These IR's will be reviewed on a daily basis for reporting to Arizona Health Care Cost Containment System (AHCCCS), by the Division's HCS Quality Assurance Registered Nurse. In addition, a report could be made to the appropriate regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, and Arizona State Board of Nursing).

6003-A DEFINITIONS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Action: a written decision made by the Division not agreed upon by the member/responsible person, when Arizona Long Term Care System (ALTCS) actions include:

A. Service denial or a limited authorization (an authorization in an amount, duration or scope less than what is ordered or requested) of a requested service, including the type or level of service, is granted; or

B. A previously authorized service is reduced, suspended, or terminated;

C. Payment for a service, in whole or in part, is denied in accordance with the Arizona Administrative Codes;

D. Authorization of services not initiated in a timely manner; or,

E. A request by a member, who resides in a rural area with only one health plan, is denied his/her right to obtain services outside the network.

ALTCS Notice of Action: the written notice to the affected member regarding an action by the Division.

Appeal: formal process under ALTCS to request a review of an action taken by the Division.

Administrative Decision: the formal decision made by the Office of Compliance and Review (OCR) related to a state funded service, including eligibility.

Administrative Review: formal review and investigation of the stated issues conducted by the OCR or assigned designee.

Grievance: a member/responsible person's expression of dissatisfaction with any aspect of a member's care not involving an action.

Notice of Intended Action: a letter from the Division related to a state funded service informing the member/responsible person of the decision and the member/responsible person's due process rights.

Notice of Appeal Resolution: the formal written decision made by the OCR regarding an ALTCS covered service.

6003-B INFORMAL RESOLUTION/GRIEVANCE PROCESS NON-ARIZONA LONG TERM CARE SERVICES

REVISION DATE: 7/22/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

A member/responsible person may have a grievance or expression of dissatisfaction with any aspect of his/her care such as a quality of care issue or problems related to communication or courtesy. A member or his/her responsible person will be encouraged to discuss any problems with the Support Coordinator as soon as they arise to seek resolution. The Support Coordinator is responsible for reviewing the grievance(s) and attempting to resolve it informally before the grievance is elevated to the Office of Family and Community Resources.

If necessary, the Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution. At any time, the member or his/her responsible person may contact the Support Coordinator's Supervisor or Program Manager.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone, or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint, and that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the progress notes.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Office of Family and Community Resources will advise the member or his/her responsible person in writing of the resolution of the grievance no later than ninety (90) calendar days from the receipt of the grievance and will record all results in the Resolution System .

6003-C APPEAL PROCESS FOR MEMBERS WHO RECEIVE STATE FUNDED SERVICES

REVISION DATE: 2/26/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the Department of Economic Security (DES) Office of Appeals. The appeal request must be made in writing and received by Office of Compliance and Review (OCR) no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OCR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and the record supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified by the Hearing Officer of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than 15 calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The Board will issue a final written decision on the matter within a reasonable time period.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-D NOTICE OF INTENDED ACTION (STATE ONLY)

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1802

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

A. Service denial, change, reduction, termination; or,

B. Eligibility is denied or terminated.

The notice must be issued on the Division form, *Notice of Intended Action* or *Service System Discharge*, and include the following information:

A. The name and address of the responsible person;

B. The date that the notice is mailed;

C. The name of the member affected by this action;

D. The action that is being taken;

E. The effective date of the action;

F. The reason for the action;

G. What the member/responsible person can do if he/she does not agree with the action being taken; and,

H. The signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with interpretation.

6003-E ADMINISTRATIVE REVIEW PROCESS (STATE ONLY)

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1803

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Compliance and Review (OCR). Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.

B. Responsible person's name, relationship, and telephone number.

C. Support Coordinator's name and telephone number.

D. Physician's name, if applicable.

E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

OCR will complete a review and investigation of the stated issues. OCR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OCR within 5 calendar days. OCR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.

There will be no change in the member's status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if necessitated by a change in health status).

6003-F FAIR HEARINGS AND APPEALS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Further appeal options depend on whether the member is Arizona Long Term Care Service (ALTCS) eligible or whether he/she receives state funded services. There are common components to the two appeal processes, which include:

A. The hearing must be held at the established hearing location that is most convenient for the member or responsible person. The member and his/her responsible person must be informed of the date, time, and location of the hearing no less than 20 calendar days in advance for standard requests. At the discretion of the hearing officer, the hearing can be conducted by telephone.

B. The hearing notice must state that the member or responsible person has the right to:

   1. Present his/her case in person or by telephone;

   2. Receive a copy of all case file documents, and any material that the Division will use in the hearing at a reasonable time before the hearing;

   3. Obtain assistance from the Division local office in preparing his/her case;

   4. Make inquiry at the Division local office concerning the availability of free legal resources; and

   5. Request a change of the hearing officer.

C. Hearings must be conducted in an orderly manner by the hearing officer. The hearing officer can rule on the admissibility of evidence, and include or exclude witnesses. Parties may present evidence, cross examine witnesses, and present arguments.

D. A complete record is made of all hearings. The member and his/her responsible person may inspect the record at a location that is accessible to them.

E. The hearing decision must be based solely on the evidence and testimony presented at the hearing, appropriate state and federal law, and applicable Department of Economic Security (DES) rules.

6003-G ARIZONA LONG TERM CARE SERVICE GRIEVANCE PROCESS

REVISION DATE: 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

State Only

A member or his/her responsible person may have a complaint regarding an issue unrelated to a Notice of Intended Action, such as a quality of care issue or problems related to communication or courtesy. Members and their responsible persons will be encouraged to discuss any problems or complaints with the Support Coordinator as soon as they arise. The Support Coordinator is responsible for reviewing and investigating complaints and attempting to resolve them informally before they reach the grievance stage. The Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone, or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

Arizona Long Term Care Service Members

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint, and the fact that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the case notes.

The Division will acknowledge receipt of a grievance orally or in writing. Receipt of grievances will be recorded in the Resolution Tracking System.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will provide written or oral notice of the grievance decision within 90 calendar days after the Division receives the grievance and will record all results in the Resolution Tracking System.

6003-H ARIZONA LONG TERM CARE SERVICE NOTICE OF ACTION

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Reasons for Use

A Support Coordinator/designee or health plan representative must issue a written Notice of Action to any member/responsible person or authorized legal representative who receives services from the Division when the member or responsible person is not in agreement to an action that results in a requested service not being authorized in the amount, duration, or scope which was ordered/requested.

Standard Request

A Support Coordinator/designee or health plan representative will issue a written Notice of Action within 14 calendar days of the request for authorization of a service for a standard request to reduce, suspend, or terminate an authorized service.

Expedited Request

The Division will expedite a request if it is determined that taking the time for a standard request could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In these circumstances, the decision must be made within 3 working days from the date of receipt of a service request, with a possible extension of up to an additional 14 calendar days if the criteria for an extension are met.

A Notice of Action will be issued within 3 working days for denial of a service request in which an expedited decision was requested. If a service requested is denied after a Notice of Extension was issued, a Notice of Action will be issued.

If a service request does not seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the expedited request may be downgraded to a standard request. When an expedited request is denied, the Division will promptly contact the member/responsible person orally to advise him/her of the denial to expedite the request. The Division will follow the oral notification with written notice of denial no later than 2 calendar days to the member/responsible person. If the member/responsible person disagree, he/she is allowed to submit additional documentation to support the expedited request.

Notice of Extension

A Notice of Extension may be issued for up to 14 additional days if the Division requires further information to make a decision and it is in the member's best interest. When additional information is not received within the timeframes allowed, the service request will be denied.

Format

The notice must be issued on Division or health plan letterhead, written in an easily understood manner, and available in alternate formats. The notice must include the following information:

A. The name and address of the responsible person;

B. The date that the notice is mailed;

C. The name of the member affected by this action;

D. The action that has been taken or intends to be taken;

E. The effective date of the action. A Notice for a previously authorized service must be sent at least 10 days before the date of the proposed termination, suspension, or reduction;

F. The reason for the action;

G. What the member/responsible person can do if he/she does not agree with this action;

H. How to request an expedited resolution of the appeal;

I. The circumstances under which services can be continued pending resolution of the appeal; and,

J. The signature of the person authorized to make the decision regarding the determinations noted previously.

6003-I ARIZONA LONG TERM CARE SERVICES APPEAL PROCESS

REVISION DATE: 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R9-34-209, R9-34-216.

Filing an Appeal

When a Notice of Action is given by the Division or health plan representative with whom the member/responsible person does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person. The Division will not take punitive action against a service provider who requests a resolution of the appeal or who supports the member's request for a resolution of the appeal.

The member/responsible person/authorized representative must file the appeal within 60 calendar days after the date of the Notice of Action either orally or in writing with the Office of Compliance and Review (OCR) at:

DDD Office of Compliance and Review
3443 N Central Ave, 9th Floor
Suite 916
Phoenix, Arizona 85012
602-771-8163 or 1-855-888-3106

At the time the appeal is filed, the member/responsible person/authorized representative may request an expedited appeal. OCR will acknowledge receipt of standard appeals in writing within five calendar days.

The Division will assist the member/responsible person with the completion of forms and other procedural steps, upon request. The member/responsible person/authorized representative may present information to the Division in person or in writing at any time during the appeal process. The member/responsible person may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law. The Division ensures the member/responsible person/authorized representative is included as a party to the appeal process.

Standard Appeal Resolution Timeframe

The Division will respond to the standard appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within thirty (30) calendar days after the date the Division receives the appeal. The Division will extend the 30-day time frame up to an additional 14 calendar days upon request by the member/responsible person. The Division may request a 14 calendar day extension of the 30-day time-frame if additional information is needed and the extension is in the best interest of the member. The OCR will provide the member/ responsible person written

notice of the reason for the decision to extend the 30-day time frame.

Expedited Appeals

The member/responsible person/authorized representative may request an expedited resolution of the appeal. The Division will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, OCR will promptly contact the member/responsible person orally to advise him/her of the denial. OCR will send written notice of the denial no later than 2 calendar days to the member/responsible person. If a request for an expedited appeal is denied, the Division will follow the standard appeal resolution timeframe and the appeal will be resolved no later than 30 calendar days after the day the Division received the appeal.

If the request for an expedited appeal is granted, OCR will promptly contact the member/responsible person orally to advise him/her of the approval. The Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within 3 working days after the day the Division receives the request for an expedited appeal. The Division will extend the 3-day time frame up to an additional 14 calendar days upon request by the member/ responsible person. The Division may request a 14 calendar day extension of the 3-day time frame if additional information is needed and the extension is in the best interest of the member. OCR will provide the member/responsible person written notice of the reason for the decision to extend the 3-day time frame.

Appeal Decisions and Timeframes

The Division will ensure that the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 3 working days for an expedited, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/authorized representative. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and,

D. The member/responsible person's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) decision.

If the Notice of Appeal Resolution is reversed, OCR will notify Support Coordination and the Health Plan, as appropriate. Upon notification services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division has the right to recover the cost of services from the member.

6003-J ARIZONA LONG TERM CARE SERVICES FAIR HEARING PROCESS

REVISION DATE: 6/10/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings (OAH). The fair hearing request must be filed in writing and received by Office of Compliance and Review (OCR) no later than 30 calendar days after receipt of the Notice of Appeal Resolution. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Phoenix, Arizona 85012

Once the hearing request is filed, OCR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OCR staff will submit the file to AHCCCS within five days. This file will include a cover letter, copy of the entire file, copies of the Notice of Action, request for fair hearing, investigative materials, and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is formal and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence, and the record supplied by OCR and the appellant, the ALJ will prepare written findings of fact and conclusions of law, and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate Division staff and /or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services (OALS) no later than 30 calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The rehearing will be decided by the AHCCCS Director or designee and a final written decision on the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-K CLAIM DISPUTES

REVISION DATE: 6/10/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-2903.01(.8) (.4), 41.1 092; A.A.C R9-34-402, R9-34-405

Claim Dispute Process

A Division representative or health plan representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division or a Division subcontracted health plan.

When a notice is given by the Division or a Division subcontracted health plan with which the service provider does not agree, the service provider may file a claim dispute. A claim dispute will be accepted by the Division or the Division subcontracted health plan only if the dispute involves a payment of a claim, denial of a claim, an imposition of a sanction, or reinsurance.

The service provider must file the claim dispute in writing with either the Division or the Division subcontracted health plan. The claim dispute must be filed within 12 months after the date(s) of service, within 12 months after the date that the member's eligibility is posted or within 60 days after the date of the denial of a timely claim submission.

If the service provider submits the claim dispute directly to the Division subcontracted health plan, the Division subcontracted health plan will forward a copy of the claim dispute to the Division upon receipt. The Division or the Division subcontracted health plans date all claim disputes upon receipt. The Division or the Division subcontracted health plan will send the service provider a written notice acknowledging receipt of the claim dispute within five working days from the date the claim dispute is received. The Division or Division subcontracted health plan will advise the service provider that any additional information the service provider wishes to submit to the Division for consideration must be done so in 10 calendar days.

Office of Compliance and Review (OCR) staff may contact the service provider and the Division subcontracted health plan to obtain additional information. Division subcontracted health plans are required to provide all information related to their recommendation to deny or approve the claim dispute to OCR no later than 10 days after the Division subcontracted health plan receives the claim dispute. Relevant policies will be reviewed and Central Office staff will be consulted as necessary.

All claim disputes are thoroughly investigated using applicable authorities and facts obtained from all parties. The Division will issue a letter to the provider if there is a mutual agreement to extend the decision due date to allow the Division to make a decision or allow the provider additional time to submit supporting documentation. All extensions must be agreed upon by both parties. Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within 30 calendar days of receipt of the services provider's claim dispute unless the provider and the contractor agree to a longer period.

The Notice of Decision complies with regulatory and contractual requirements and includes:

A. The date of the decision;

B. The factual and legal basis for the decision; and,

C The service provider's right to request a fair hearing and how to do so.

State Fair Hearings for Claim Disputes

When a service provider does not agree with a Notice of Decision by the Division on a claim dispute, the service provider may file a request for a fair hearing by the Department of Economic Security (DES) Appellate Services Administration/Arizona Long Term Care System (ALTCS). The request for fair hearing must be made in writing and received by the OCR no later than 30 calendar days after receipt of the Notice of Decision. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file along with the hearing request for submission to the DES Appellate Services Administration/ALTCS and the Attorney General's Office. This file will include copies of the claim dispute, investigative materials, and the Notice of Decision.

The hearing will be scheduled by a DES Appellate Services Administration/ALTCS representative, and the service provider will receive written notification of the date and time. The DES Appellate Services Administration/ALTCS representative will also notify the Attorney General's Office and OCR of the scheduled hearing.

At the hearing, the service provider, a DES/Division of Developmental Disabilities (DDD) representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/ALTCS Hearing Officer. The rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and other records supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision. The DES Appellate Services Administration/ALTCS representative will forward a copy of the decision to the Arizona Health Care Cost Containment Service (AHCCCS) Office of Administrative Legal Services, the service provider, DES/DDD and the Attorney General's Office.

Petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the DES Appellate Services Administration/ALTCS Administrative Law Judge. The petition must completely explain the grounds on which rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate Division staff and/or subcontracted health plan staff to authorize and make payment for the services as expeditiously as possible.

If the service provider is still not satisfied with the decision, the service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overturned or Reversed Claim Disputes

The Division or its subcontractors shall reprocess and pay overturned or reversed claim disputes within 15 business days of the date of the decision. The Division or its' subcontractors will make payments in a manner consistent with the decision.

6003-L ATTORNEYS AT PLANNING MEETINGS

REVISION DATE: 5/20/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

The member/responsible person may invite anyone to participate at planning meetings, including his/her attorney. It is recommended that the member/responsible person notify the Support Coordinator, at least two business days before the meeting is scheduled to occur, that legal counsel will participate with the responsible person at the planning meeting.

If prior notice is not given, the planning meeting may be postponed. If the Division's legal counsel is not present at the meeting and Division staff determines that legal counsel is needed, Division staff may temporarily stop the meeting in an effort to obtain legal counsel. In addition to Division staff, the Division may have an Assistant Attorney General at a meeting. Any meeting may be audio recorded.

6003-M CONDUCTING ALL MEETINGS

REVISION DATE: 2/26/2016, 1/15/16, 3/2/2015
EFFECTIVE DATE: July 31, 1993

To provide defined objectives and to allow for adequate meeting facilities complete the following:

A. Clarify the purpose of the meeting;

B. Check with the member/responsible person as to how many people they will have in attendance so adequate space will be provided and clarify with the family the names and titles of those attending from the Division; and,

C. Schedule space appropriate for the number of people in attendance.

Tape Recording Meetings

Unless there are either pending grievances or legal actions, there is no prohibition for members/responsible persons to tape record Individual Support Plan (ISP) meetings. Canceling a meeting for this reason is not acceptable.

Requests for Member Information

In order to ensure uniformity and conformity, all requests for member information must be cleared through the Office of Compliance and Review (OCR). Situations include, but are not limited to:

A. Any circumstance where staff may deem it necessary to initiate contact with an attorney or his/her staff; or,

B. Any request for member records or communication regarding a member's services unless prior authorized by the OCR.

6004-A QUALITY MANAGEMENT

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-550, 36-595 et seq.; A.A.C. R6-6, R9-28, R9-33, R6-18; 42 CFR 438.66

The purpose of Quality Management is to monitor and assure the quality of all care and services provided to individuals through a coordinated, comprehensive, and continuous effort. The goals of Quality Management include:

A. Ensuring services are available, accessible, timely, safe, supportive, and appropriate.

B. Providing ongoing, objective, and systematic measurement, analysis, and trending to facilitate performance improvement efforts.

C. Oversight for determining quality, efficiency, and effectiveness of service delivery.

Division employees are responsible for internal oversight of the following Quality Management activities: ensuring providers are compliant with requirements of external entities; providing oversight of Support Coordination; providing oversight of the Division's contracted Health Plans; and oversight of a variety of services; and settings such as:

A. Assisted living facilities;

B. Individual's home (not contracted with the Division);

C. Day programs (Day Treatment and Training (child and adult));

D. Employment programs;

E. Nursing facilities;

F. Provider's home; or,

G. Residential settings (group homes, Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), developmental homes).

6004-B INTERNAL OVERSIGHT

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993

Monitoring

The Division's program and contract monitoring activities provide oversight of services around a set of minimum expectations as documented in statute, rule, and contract. The Division's Program Monitors review all residential settings as required for programmatic and contractual compliance as well as compliance with licensing and certification requirements. Additional monitoring of services may occur depending on Division requirements.

Continued Stay Reviews

Continued Stay Reviews ensure the appropriateness and necessity of an ICF/ID level of care through reviews of health and programmatic records. The review also assesses the quality of care and assists in discharge planning.

Quality Management staff must review each individual within six (6) months of admission and at least every six (6) months thereafter. Reviewers evaluate the physician's certificate of need for care, medical evaluations, the plan of care, and the facility's Utilization Control Plan in relation to the individual's community integration and placement in the least restrictive environment.

Program Operations and Business Operations

Prior to receiving a contract, Division staff will ensure applicants have completed all the necessary steps, and qualify as a provider for the Division. Division employees at the District and Central Office are required to provide oversight of contracted providers to ensure contract compliance.

Support Coordination

Support Coordination serves as the first level of oversight to ensure Division funded settings and services are meeting the individual's needs. This oversight can take place during a review and/or annual planning meeting and includes an assessment of the placement and/or provider's ability to meet the individual's needs. On-site reviews shall be conducted while the individual is present.

Support Coordination is responsible for reporting any concerns regarding the setting or the provider's ability to meet individual's needs using the incident reporting system. See Chapter 2100 for further details.
Support Coordination is also responsible for ensuring the implementation of the Arizona Long Term Care System (ALTCS) program as described in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual. This includes oversight of all services in all settings.

Health Care Services

Health Care Services serves as the first level of oversight to ensure contracted health plans comply with their contract.

In addition to the reviews completed by the Support Coordinator, Health Care Services nurses complete utilization/concurrent reviews to ensure individuals are receiving the appropriate level of nursing care. This oversight can be provided in all settings.

Arizona Long Term Care System Administrator/Specialists

The ALTCS Administrator oversees the entire ALTCS program including oversight of the ALTCS Specialists/designees who audit case files to monitor support coordination compliance with the ALTCS program.

The Division monitors implementation of the ALTCS and Targeted Support Coordination (TSC) programs through the use of specific audit tools. Data gathered is analyzed to identify Support Coordination system issues and corrective action plans are developed as appropriate.

Arizona Long Term Care System

A. An ALTCS audit monitors completion of timely planning meetings by a review of case files. Documentation in the case file must establish the following:

   1. The member's presence and participation with support as needed in the development of the planning document.

   2. The meeting occurred at the member's home unless documentation indicates the member/responsible person has chosen an alternate location. At least one ISP/review must occur in the individual's home every twelve months.

   3. An acceptable reason when the planning meeting occurs after the due date.

B. The ALTCS On-Site and Timeliness Audit are used to monitor timeliness of planning meetings. To achieve timeliness, a planning meeting must have occurred:

   1. Within the required interval based on a comparison of the date of the most current and the previous review (prior timeliness); and,

   2. On the date of the audit, all planning meetings must be current. (Current timeliness).

The Division completes this audit on 100% of the ALTCS cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

C. The Support Coordinator ALTCS Audit is used to monitor the Division's compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM.) Quarterly, the District must complete a minimum of two Support Coordinator ALTCS audits for every Support Coordinator position allocated, including vacant positions. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

Targeted Support Coordination

A. The TSC audits monitor completion of a timely planning meeting through a review of documentation contained in a member's file Documentation must establish the following:

1. The planning meeting was held at the frequency requested by the member/responsible person using the contact type requested; and,

2. An acceptable reason if the planning meeting occurred after the due date.

B. The Targeted Timeliness Audit is used to monitor completion of a timely planning meeting through a review of documentation contained in a member's file. Documentation must establish the following:

1. At least annually, the type and frequency of contact chosen;

2. When the member receives a service that has a "mandated minimum review cycle" requirement, the chosen contact type and frequency do not exceed the "mandated minimum review cycle."

3. The planning meeting is within requested/required intervals based on a comparison of the date of the most current and the previous review (prior timeliness).

4. The most current planning meeting is within the required interval when compared to the date of the audit (current timeliness).

The Division completes audits on 100% of the Targeted cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

C. The Targeted Support Coordination Audit is used to monitor the Division's compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM). Quarterly, each District completes audits on 10% of their Targeted Support Coordination cases. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

Other

Additional Division employees are responsible for oversight activities such as tracking, trending, and reporting issues related to Quality Management.

Additional oversight of Support Coordination occurs at the District and Central Office level.

6004-C EXTERNAL OVERSIGHT

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993

Licensing/Certification

For settings that require licensing and/or certification, the entities that provide the license and/or certification also have oversight responsibilities. Entities responsible for oversight include:

A. U.S. Department of Labor;

B. Arizona Department of Health Services (DHS);

C. Arizona DHS, Division of Behavioral Health Services (DBHS);

D. Arizona DHS, Division of Licensing Services, Office of Long-Term Care Licensing; and,

E. Arizona Department of Economic Security (DES), Office of Licensing, Certification and Regulation (OLCR).

Arizona Health Care Cost Containment System

Arizona Health Care Cost Containment System (AHCCCS), as the Single State Medicaid agency, has the authority to inspect Arizona Long Term Care System (ALTCS) funded settings at any time. The purpose of AHCCCS oversight is to ensure compliance with the standards set forth in the AHCCCS Medical Policy Manual (AMPM). The Division, as an ALTCS program contractor, is required to ensure that all ALTCS eligible individuals are receiving services as medically needed. This process typically involves review of support coordination functions as they relate to the Planning Document. AHCCCS may or may not actually visit the site during the review.

Advocacy

Advocacy agencies have the authority to review residential settings in the community at reasonable times. This authority was granted because of the Arizona Training Program Coolidge lawsuit (*Griswold vs. Riley*) and is noted in Arizona Revised Statutes. This includes the Developmental Disabilities Advisory Council.

Financial Audit

All agencies with a contract are subject to the programmatic and fiscal monitoring requirements of the Department to ensure accountability of the delivery of all goods and services. Specific requirements are delineated in the provider's contract.

6004-D DIVISION OVERSIGHT FINDINGS

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993

When deficiencies are identified, the scope and severity of the deficiencies as well as the oversight activity, will determine the next steps. At a minimum, the Division may request a Corrective Action Plan from the Provider.

6004-E OPERATIONAL REVIEWS

EFFECTIVE DATE: May 20, 2016
REFERENCES: 42 CFR Part 438, AHCCCS 1115 Waiver

Purpose of Operational Reviews

The purpose of the Division performing an Operational Review (OR) is to:

A. Know the Contractor's system and operation.

B. Support Contractor compliance with Division requirements.

C. Improve Contractor's compliance with Division requirements.

D. Recognize Contractor accomplishments.

E. Perform Contractor oversight as required by the Centers for Medicare and Medicaid Services (CMS), in accordance with the Arizona Health Care Cost Control System (AHCCCS) 1115 Waiver.

F. Determine whether the Contractor satisfactorily meets:

1. Division contract requirements
2. Division policies
3. Arizona Revised Statute
4. Arizona Administrative Code
5. 42 CFR Part 438, Managed Care.

G. Determine progress made in implementing recommendations made during prior reviews.

H. Determine Contractor compliance with its own policies and procedures.

I. Evaluate the effectiveness of Contractor policies and procedures.

Types of Operational Reviews

The following are types of Operational Reviews:

A. Full Review, which includes a review of all standards

B. Focused Review, which includes review of specific:

1. Areas across all Contractors, e.g., implementation of value based purchasing
2. Standards related to individual Contractor performance.

Prior to Onsite Review Timeline

The timeline for performing Operational Reviews is as follows:

A. Three (3) weeks before onsite review, the Division provides formal notification of the onsite review to the Contractor.

B. Two (2) weeks before onsite review, the Contractor submits the first documents, which include Populations for Samples, e.g., Prior Approval (PA) Logs.

C. Within three (3) days of receipt of above documents, the Division notifies Contractor of which samples will be reviewed.

D. One (1) week before onsite review, the Contractor uploads all documents to the Division's File Transfer Protocol (FTP) site.

After Onsite Review Timeline

After the onsite review occurs, the following occur:

A. Six (6) weeks after the onsite review, the Division forwards a draft of its findings to the Contractor.

B. Within one week after above action, the Contractor may challenge The Division's finding by submitting a Challenge Letter to the Division.

C. Nine (9) weeks after the onsite review, the Division issues its Final Report.

D. Eleven (11) weeks after the onsite review, the Contractor Corrective Action Plan(s) (CAP) is due to the Division.

E. Six (6) months after the Division approves the CAP approval – CAPs must be completed and closed.

The Process – Document Review

The Division reviews documents at the Contractor's place of business (on-site), off-site, or a combination of both.

When the Division requests additional documents:

1. Before noon, the Contractor supplies the documents by close of business on the same day.

2. After noon, the Contractor supplies the documents by 9:00 a.m. on the following day.

OR Categories

OR Categories are:

A. Case Management (CM)

B. Claims and Information Systems (CIS)

C. Delivery Systems (DS)

D. General Administration (GA)

E. Grievance System (GS)

F. Maternal/Child Health and EPSDT (MCH)

G. Medical Management (MM)

H. Member Information (MI)

I. Quality Management (QM)

J. Reinsurance (RI)

K. Third Party Liability (TPL)

L. Corporate Compliance (CC).

6004-F COMPLIANCE PROGRAM

EFFECTIVE DATE: June 10, 2016
REFERENCES: 42 CFR 438.230(b), 42 CFR 438.608, ACOM Policy 103

Compliance Program Overview

The Division Compliance Program consists of the development, maintenance, and implementation of Policies and Procedures, and the use of training materials, to ensure the Division and its personnel, and contract providers (e.g., Qualified Vendors, and Administrative Services subcontractors) meet all legal and regulatory requirements in the performance of their duties.

The Division ensures compliance with all federal, state, and local requirements, including but not limited to, those identified in:

A. 42 Code of Federal Regulation (CFR)

B. Health Insurance Portability and Accountability Act (HIPAA)

C. Arizona Revised Statutes (ARS)

D. Arizona Administrative Code (AAC)

E. The Division's Contract with the Arizona Health Care Cost Containment System (AHCCCS).

Responsibility for Compliance Program Structure

The following personnel monitor, review, and assess the effectiveness of the compliance program and the timeliness of reporting to ensure that the Compliance Program structure facilitates compliance with all legal and governmental requirements:

A. The Compliance Officer

B. Compliance Committee (consisting of Compliance Officer, a budgetary official, Executive Management and others with the ability to commit resources).

Responsibility for Compliance Program Implementation

The following personnel manage the Compliance Program to ensure compliance with all legal and governmental requirements:

A. The Compliance Officer, and all other Division management

B. Human Resources personnel

C. All other employees.

Compliance Program Components

The Division Compliance Program is based on the Division's Corporate Compliance Plan, policies, procedures, training/updates, monitoring, oversight of compliance to law and contractual obligations, and enforcement.

A. Corporate Compliance Plan

Implementation of the Division's Corporate Compliance Plan prevents and detects fraud, waste, and abuse; the Plan:

1. Identifies the location of written criteria for selecting a Compliance Officer
2. Includes the Compliance Officer job description, clearly outlining the responsibilities and authority of the Compliance Officer, who reports directly to the Division's Assistant Director and whose office is located at the Division's Central Office
3. Is administered and monitored by the Compliance Officer/delegate.
4. Describes:
   a. Lines of communication between the Compliance Officer and Division employees
   b. Enforcement through well-publicized disciplinary guidelines
   c. Internal and external monitoring/auditing and related reporting
   d. Division compliance with the Deficit Reduction Act of 2005
   e. Training requirements for the Division, subcontractors and providers
   f. Notification requirements pertaining to CMS compliance issues related to HIPAA transaction and code set complaints.
5. Adheres to ACOM Policy 103 and the Division's contract with AHCCCS
6. Is submitted annually to AHCCCS Office of Inspector General (OIG).

B. Policies and Procedures

The Compliance Program is based on written Policies, Procedures, and material that facilitate compliance with federal and state laws, regulations, and contractual requirements.

Pursuant to the Deficit Reduction Act of 2005, written Policies address the Federal False Claims Act, administrative remedies for false claims/statements, civil and criminal penalties for false claims/statements, and whistleblower protections under law. See Operations Manual Policy 6002-N Fraud and False Claims, Provider Manual Chapter 20 Fraud, Waste and Abuse, and Provider Manual Chapter 21 False Claims Act.

C. Training and Updates

1. Mandatory Training

a. In a manner that can be verified by AHCCCS, the Division trains all employees (including Management) on the following:

i. Compliance

ii. Article 9

iii. HIPAA

iv. Standards of Conduct for State Employees

v. Fraud Awareness

vi. Business Continuity

vii. Diversity

viii. AHCCCS Overview

b. The Division trains employees as appropriate to their job functions, including but not limited to:

i. Support Coordination/Member Services

ii. Network/Provider Relations

iii. Medical Management

iv. Quality Management

c. The Division provides refresher training to all employees, and to employees as appropriate to their job functions, as needed

2. Training Materials

   The DES Office of Professional Development develops and maintains all training materials. Training materials are reviewed and updated as needed by Division employees.

3. Updates

   a. The Division may provide updates, to Division personnel, communicated in the following formats:

      i. Unit meetings

      ii. Statewide meetings

      iii. E-mails

      iv. Policies and procedures.

   b. The Division may provide updates to contract providers in the following formats:

      i. Provider/coordination meetings

      ii. Vendor Blasts/e-mails

      iii. Policies and procedural manuals

      iv. Contract amendments.

D. Contracts with Administrative Services Subcontractors

The Division:

1. Evaluates the ability of prospective providers to perform the activities to be delegated.

2. Establishes a written agreement (as defined by the Division's contract with AHCCCS) that:

   a. Specifies activities and reporting responsibilities delegated to the contractor

   b. Provides for revocation of such delegation, and application of sanctions

   c. Includes other specific requirements, as stated in the Division's contract with AHCCCS.

3. Retains authority to direct delegated contract requirements

4. Communicates deficiencies to the provider so that the provider is able to develop a Corrective Action Plan (42 CFR 438.230[b]).

E. Compliance Monitoring and Enforcement

1. Monitoring

The Division monitors compliance via:

a. Compliance-related reports based on Division and provider data

b. Investigations of allegations of non-compliance

c. Review of functional areas and related systems

d. Assessment of mechanisms to facilitate detection of non-compliance

e. Internal and external audits.

2. Reporting of Noncompliance to the Division

The Division maintains open lines of communication and supports Division personnel, contract providers, members, and all other individuals in reporting non-compliance. Means of reporting non-compliance to the Division include:

a. Toll-free telephone hotlines identified in Division publications

b. Email addresses identified in Division publications and accessible via the Division website.

3. Division Reporting of Noncompliance to AHCCCS

Upon learning of a potential incident of fraud, waste or abuse involving an AHCCCS Program, the Division:

a. May conduct a preliminary fact-finding to determine the nature of the incident

b. Completes the confidential AHCCCS Referral for Preliminary Investigation form available on the AHCCCS website (for member and provider cases)

c. Notifies the AHCCCS-Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity in accordance within ten days of discovery per AHCCCS ACOM Policy 103.

4. Enforcement

The Division:

a. Responds to compliance issues to the extent required by law and within the mandated timeframes

b. Enforces compliance and takes corrective actions as appropriate.

5. Reports

The Division generates regular compliance-related reports that include, but are not limited to:

a. Grievance System Report

b. Resolution System Report

c. CLT_0060 (high utilization by members) and CLT-0150 (underutilization by members); see Policy 6002-N Fraud and False Claims

d. Claims Dashboard

e. Support Coordination Reports.