Chapter 5:

Quality Management

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5.0 HEALTH CHOICE QUALITY MANAGEMENT OVERVIEW

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

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

5.1 QUALITY OF CARE (QOC) AND SERVICE COMPLAINTS

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

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

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

The Quality Management/Performance Improvement Committee (QM/PIC), chaired by the Chief Medical Officer (CMO) or his/her designee, provides oversight for the QM/PI Program and is responsible for the quality of care and peer review functions. Contracted physicians, representing a variety of medical specialties, serve on the Committee and/or related sub-committees (e.g. Peer Review) and are appointed by the CMO. If the specialty being reviewed is not represented on Peer Review Committee, Blue Cross Blue Shield of Arizona Health Choice shall utilize peers of the same or similar specialty through external consultation,

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

5.2 PEER REVIEW

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

Any report of a deficiency in the quality of care (QOC) or the omission of care or service by a provider is subject to peer review. Referrals of potential peer review issues may be initiated by external or by any internal Blue Cross Blue Shield of Arizona Health Choice department with a potential referral to QM for research and review. Internal sources may include Blue Cross Blue Shield of Arizona Health Choice department staff members who identify potential specific peer review quality issues while conducting their daily operations, member or provider appeals, medical committees, provider profiling reports, on-site provider reviews and utilization management reports. Internal potential QOC referrals are sent to the QM department documented on a *grievance/complaint form* with an attachment of any supporting documentation such as utilization reports, excerpts of medical progress notes, or other pertinent documents available. External sources include state and/or federal agencies, media reports, other providers, members, member representatives, advocates, and caregivers.

Information from external sources may be received by Blue Cross Blue Shield of Arizona Health Choice via a letter, phone calls directly to the Chief Medical Officer/Medical Director, or email. If you are interested in participating in the Quality/Peer Review Committee, please call the Director of Quality Management at (602) 829-3355. All committee members must be licensed practitioners and sign confidentiality agreements.

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

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

The QM/PIC Executive peer review session is responsible for reporting quality issues and Blue Cross Blue Shield of Arizona Health Choice actions regarding these issues, as required or allowed by law, to the appropriate authorities including but not limited to, the Board of Medical Examiners, Osteopathic Board, Podiatric Board, and the National Practitioners Data Bank. Under

the Chief Medical Officer/Medical Director's direction, agencies will be notified of the QM/PIC Executive peer review session's decision regarding adverse actions.

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

The formal peer review process is accomplished by evaluating the clinical activities and qualifications of practitioners and providers through the efforts of the QM Department and other review committees of Blue Cross Blue Shield of Arizona Health Choice. This process is pursuant to A.R.S. 36-2401 et seq. and 36-2917 ("Arizona Peer Review Laws"). If an adverse action is taken against a provider as a result of the peer review process, the provider has certain appeal rights. The provider has the right to appeal the following:

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

5.3 MEDICAL RECORD STANDARDS

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

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

Should a provider use a vendor to provide copies of medical records, such as HealthPort, providers shall notify vendors of the requirement to provide records to health plans, at no cost, as per the following Arizona Administrative Code:

Federal and State Legal Reference:
Arizona Administrative Code R9-22-512 (E)
A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

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

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

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

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

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

- Annual Well Visit
- Date of last cervical cancer screening
- Date of mammogram screening
- Prostate screening
- Alcohol, smoking, or substance abuse assessment and treatment recommendations
- Exercise recommendation
- Nutritional status body mass index (BMI) and weight deviations from normal
- Immunizations

- Family planning counseling
- Children Dental Visit
- Colorectal Cancer Screening
- Diabetic Eye Exam
- Diabetic Blood Sugar Control
- Diabetic Monitoring for Nephropathy
- Medication Adherence
- When to use the ED or urgent care Medication Review (Reconciliation)
- Osteoporosis Management in Women with Prior Fractures

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

- Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.
- Member identification information on each page of the medical record (i.e.name or identification number).
- Documentation of identifying demographics including the member's name, address, telephone number, identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
- Initial history for the member that includes family medical history, social history, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member).
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received.
- Immunization records (required for children; recommended for adult members if available.
- Dental history, if available, and current dental needs and/or services.
- Current problem list
- Current medications
- Documentation, initialed by the member's provider, to signify review of:
    - Diagnostic information including:
    - Laboratory tests and screenings,
    - Radiology reports,
    - Physical examinations notes, and
    - Other pertinent data
    - Reports from referrals, consultations, and specialists,
    - Emergency/urgent care reports.
    - Hospital discharge summaries,
    - Behavioral health referrals and services provided, if applicable, including notification

of behavioral health providers, if known, when a member's health status changes or new medications are prescribed.

- Behavioral health history and information.
- Documentation as to whether or not an adult member has completed advance directives and location of the document.
- Documentation that the provider responds to behavioral health provider information request within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.
- Documentation related to requests for release of information and subsequent releases.
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- Obstetric providers must complete a standardized, evidence –based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologist [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.
- Ensure that PCPs utilize approved developmental screening tools.
- Organization provider services (e.g. hospitals, nursing facilities, rehabilitation clinics, transportation etc.) maintain a record of services provided to the member including:
    - Physician or provider orders for the service,
    - Applicable diagnostic or evaluation documentation,
    - A plan of treatment,
    - Periodic summary of the member's progress toward treatment goals,
    - The date and description of service modalities provided, and
    - Signature/initials of the provider for each service
- Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
- Must have an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified.
- Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or professionals provide services.

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

- If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date of each entry.
- If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made;

correction fluid or tape is not allowed.

- If kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.
- If revisions to information are made, a system must be in place to track when, and by whom they are made. In addition, a back-up system including initial and revised information must be maintained. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified.
- Documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.

The member:

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

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

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

- Transmitting member records to a provider when services are rendered to the member through referral to a Contractor's subcontracted provider,
- Sharing medical records with the member's health plans.

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

ALL ORGANIZATIONAL PROVIDER OF SERVICES

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

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

or paraprofessionals provide services.

TRANSPORTATION SERVICES DOCUMENTATION

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

DISCLOSURE OF RECORDS

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

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

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

- When requested by a member's primary care provider (PCP) the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days of the request
- Blue Cross Blue Shield of Arizona Health Choice and subcontracted providers must provide each member who makes a request one copy of his or her medical record free of charge annually.
- Blue Cross Blue Shield of Arizona Health Choice and subcontracted providers must allow, upon request, recipients to view and amend their medical record as specified in 45 C.F.R. § 164.524,

164.526 and A.R.S. § 12-2293.

Behavioral health records must contain the following elements:

- Intake paperwork documentation that includes:
  - Documentation of recipient's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
  - Contact information for the member's PCP if applicable.
- Assessment documentation that includes:
  - Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information
  - Diagnostic information including psychiatric, psychological, and medical evaluations;
  - An English version of the assessment and/or service plan if the documents are completed in any other language other than English; and
  - For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.
- Treatment and service plans documentation that includes:
  - The recipient's treatment and service plan;
  - Progress reports or service plans from all other additional service providers.
- Progress notes documentation that includes:
  - Documentation of the type of services provided;
  - The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a primary diagnosis is identified, the person may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable;
  - The date the service was delivered;
  - The date and time the progress note was signed,
  - The signature of the staff that provided the service, including the staff member's credentials,
  - Duration of the service (time increments) including the code used for billing the service;
  - A description of what occurred during the provision of the service related to the recipient's treatment plan;
  - In the event that more than one provider simultaneously provides the same service to a recipient, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
  - The recipient's response to service; and
  - For recipients receiving services via telemedicine, electronically recorded information of direct, consultative, or collateral clinical interviews.
- Medical services documentation that includes:
  - Laboratory, x-ray, and other findings related to the member's physical and behavioral health care;
  - The members' treatment plan related to medical services;

- Physician orders;
- Requests for service authorizations;
- Documentation of facility-based or inpatient care;
- Documentation of preventative care services;
- Medication record, when applicable;
- Documentation of psychotropic and antipsychotic medication assessment by the Behavioral Health Medical Professional prior to prescribing or providing the medication; and
- Documentation of Certification of Need (CON) and Re-Certification of Need (RON when applicable.

- Reports from other agencies that include:
  - Reports from providers of services, consultations, and specialists;
  - Emergency/urgent care reports; and
  - Hospital discharge summaries.
- Paper or electronic correspondence that includes:
  - Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management of the recipient's health care;
  - Documentation of any requests for and forwarding of behavioral health record information.
- Financial documentation that includes:
  - Information regarding establishment of any copayments assessed, if applicable.
- Legal documentation including;
  - Documentation related to requests for release of information and subsequent releases
  - Copies of any advance directives or mental health care power of attorney as defined the Advance Directives section of this Chapter, including:

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

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

- A provider furnishing a referral service reports appropriate information to the referring provider.

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

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

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

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

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

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

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

5.4 ADVANCE DIRECTIVES

Hospitals, nursing facilities, hospice providers, and providers of home health care or personal care services must comply with Federal and State laws regarding advance directives for adult members [42 U.S.C. § 1396(a)(57)]. Providers must discuss advance directives with all adult members receiving medical care. Adult members and members with special healthcare needs or their representatives are provided written information about formulating advance directives that ensures involvement with the healthcare practitioner.

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

5.5 HEALTH CARE-ACQUIRED CONDITIONS AND PROVIDER-PREVENTABLE CONDITIONS

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable conditions. Provider Preventable Condition means a condition that meets the definition of a Health Care Acquired Condition (HCAC) or an Other Provider Preventable Condition (OPPC).

All HCACs or OPPCs must be reported to Quality Management.

If a potential HCAC or OPPC is identified, Quality Management will conduct a quality-of-care investigation.

A Health Care Acquired Condition (HCAC) is a Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital-Acquired Conditions.) (ICD-10 HAC List | CMS)