NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

ADMINISTRATION

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R9-22-101	Amend
R9-22-201	Amend
R9-22-202	Amend
R9-22-204	Amend
R9-22-210	Amend
R9-22-210.01	Amend
R9-22-211	Amend
R9-22-215	Amend
R9-22-217	Amend
R9-22-703	Amend
R9-22-712	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2907

Implementing statute: A.R.S. § 36-2907

3. The effective date of the rules:

Effective immediately upon filing with the Secretary of State. The Administration believes that an immediate effective date is necessary since the rule changes are less stringent than the rule that is currently in effect and the rule changes do not have an impact on the public health, safety, welfare or environment, and do not affect the public involvement and public participation process as described under A.R.S. § 41-1032 (A)(5).

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 17 A.A.R. 513, April 8, 2011

Notice of Proposed Rulemaking: 17 A.A.R. 478, April 8, 2011

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The proposed rules will eliminate the requirement for obtaining Prior Authorization (PA) for services such as, but not limited to: dialysis shunt placement, apnea management and training for premature babies up to one year of life, certain eye surgeries, and hospitalizations for labor and delivery not exceeding specific time parameters. Technical changes and striking of redundant rules will be made. In addition, a clarification to the definition of Prior Authorization will be made, to inform the public that prior authorization is not only based on medical necessity but also on the cost effectiveness of the service provided.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed or relied upon for this rulemaking.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The AHCCCS Administration believes that subjecting the identified services to PA adds administrative costs and time-consuming processes to Agency operations, further straining limited program resources without accompanying benefits. This amendment also reduces the administrative burden on health care providers and facilitates members' access to appropriate care.

Currently 95 percent of the cases are approved. The Administration believes that removal of this requirement will save the provider time and money. Each PA takes 5-10 minutes and each biller is costing a provider approximately $15 an hour, possibly saving providers $14,000 in a year. The Administration will also save time and money for the cost of the PA nurse's time, estimated to be $28,000 a year. In addition, the Administration will no longer conduct concurrent reviews, which is a review of a patient's medical necessity for hospitalization completed by the Administration at the time of hospitalization, for Federal Emergency Service (FES) members since Federal regulations and the state plan prohibit reimbursement of any services which are not emergent. A review of the medical records is completed when the claim is received so it is not necessary to spend time and effort on a concurrent review. Therefore, the reference to concurrent review is not necessary and the PA department can cease conducting these reviews, which numbered 1,980 in calendar year 2010. At $95.00 per review, the total savings estimated by eliminating concurrent review for FES hospitalizations would approach $188,100.00.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

No additional changes have been made between the proposed rules and the final rules below. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

The Administration did not receive any comments regarding the rules.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Not applicable

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section

ARTICLE 2. SCOPE OF SERVICES

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition Section or Citation

"Accommodation" R9-22-701

"Act" R9-22-101

"ADHS" R9-22-101

"Administration" A.R.S. § 36-2901

"Adverse action" R9-22-101

"Affiliated corporate organization" R9-22-101

"Aged" 42 U.S.C. 1382c(a)(1)(A) and R9-22-1501

"Aggregate" R9-22-701

"AHCCCS" R9-22-101

"AHCCCS inpatient hospital day or days of care" R9-22-701

"AHCCCS registered provider" R9-22-101

"Ambulance" A.R.S. § 36-2201

"Ancillary department" R9-22-701

"Ancillary service" R9-22-701

"Anticipatory guidance" R9-22-201

"Annual enrollment choice" R9-22-1701

"APC" R9-22-701

"Appellant" R9-22-101

"Applicant" R9-22-101

"Application" R9-22-101

"Assessment" R9-22-1101

"Assignment" R9-22-101

"Attending physician" R9-22-101

"Authorized representative" R9-22-101

"Authorization" R9-22-201

"Auto-assignment algorithm" R9-22-1701

"AZ-NBCCEDP" R9-22-2001

"Baby Arizona" R9-22-1401

"Behavior management services" R9-22-1201

"Behavioral health adult therapeutic home" R9-22-1201

"Behavioral health therapeutic home care services" R9-22-1201

"Behavioral health evaluation" R9-22-1201

"Behavioral health medical practitioner" R9-22-1201

"Behavioral health professional" R9-20-1201

"Behavioral health recipient" R9-22-201

"Behavioral health service" R9-22-1201

"Behavioral health technician" R9-20-1201

“Benefit year” R9-22-201

"BHS" R9-22-1401

"Billed charges" R9-22-701

"Blind" R9-22-1501

"Burial plot" R9-22-1401

"Business agent" R9-22-701 and R9-22-704

"Calculated inpatient costs" R9-22-712.07

"Capital costs" R9-22-701

"Capped fee-for-service" R9-22-101

"Caretaker relative" R9-22-1401

"Case management" R9-22-1201

"Case record" R9-22-101

"Case review" R9-22-101

"Cash assistance" R9-22-1401

"Categorically eligible" R9-22-101

"CCR" R9-22-712

"Certified psychiatric nurse practitioner" R9-22-1201

"Charge master" R9-22-712

"Child" R9-22-1503 and R9-22-1603

"Children's Rehabilitative Services" or "CRS" ~~R9-22-201~~ R9-22-101

"Claim" R9-22-1101

"Claims paid amount" R9-22-712.07

"Clean claim" A.R.S. § 36-2904

"Clinical supervision" R9-22-201

"CMDP" R9-22-1701

"CMS" R9-22-101

"Continuous stay" R9-22-101

"Contract" R9-22-101

"Contract year" R9-22-101

"Contractor" A.R.S. § 36-2901

"Copayment" R9-22-701, R9-22-711 and R9-22-1603

"Cost avoid" R9-22-1201

"Cost-To-Charge Ratio" R9-22-701

"Covered charges" R9-22-701

"Covered services" R9-22-101

"CPT" R9-22-701

"Creditable coverage" R9-22-2003 and 42 U.S.C. 300gg(c)

"Critical Access Hospital" R9-22-701

"CRS" ~~R9-22-1401~~ R9-22-101

"Cryotherapy" R9-22-2001

"Customized DME" R9-22-212

"Day" R9-22-101 and R9-22-1101

"Date of the Notice of Adverse Action" R9-22-1441

"DBHS" ~~R9-22-201~~ R9-22-101

"DCSE" R9-22-1401

"De novo hearing" 42 CFR 431.201

"Dentures" and "Denture services" R9-22-201

"Department" A.R.S. § 36-2901

"Dependent child" A.R.S. § 46-101

"DES" R9-22-101

"Diagnostic services" R9-22-101

"Director" R9-22-101

"Disabled" R9-22-1501

"Discussion" R9-22-101

"Disenrollment" R9-22-1701

"DME" R9-22-101

"DRI inflation factor" R9-22-701

"E.P.S.D.T. services" 42 CFR 440.40(b)

"Eligibility posting" R9-22-701

"Eligible person" A.R.S. § 36-2901

"Emergency behavioral health condition for the non-FES member" R9-22-201

"Emergency behavioral health services for the non-FES member" R9-22-201

"Emergency medical condition for the non-FES member" R9-22-201

"Emergency medical services for the non-FES member" R9-22-201

"Emergency medical or behavioral health condition for a FES member" R9-22-217

"Emergency services costs" A.R.S. § 36-2903.07

"Encounter" R9-22-701

"Enrollment" R9-22-1701

"Enumeration" R9-22-101

"Equity" R9-22-101

"Experimental services" R9-22-203

"Existing outpatient service" R9-22-701

"Expansion funds" R9-22-701

"FAA" R9-22-1401

"Facility" R9-22-101

"Factor" R9-22-701 and 42 CFR 447.10

"FBR" R9-22-101

"Federal financial participation" or "FFP" 42 CFR 400.203

"Federal poverty level" or "FPL" A.R.S. § 36-2981

"Fee-For-Service" or "FFS" R9-22-101

"FES member" R9-22-101

"FESP" R9-22-101

"First-party liability" R9-22-1001

"File" R9-22-1101

"Fiscal agent" R9-22-210

"Fiscal intermediary" R9-22-701

"Foster care maintenance payment" 42 U.S.C. 675(4)(A)

"FQHC" R9-22-101

"Free Standing Children's Hospital" R9-22-701

"Fund" R9-22-712.07

"Graduate medical education (GME) program" R9-22-701

"Grievance" R9-34-202

"GSA" R9-22-101

"HCPCS" R9-22-701

"Health care practitioner" R9-22-1201

"Hearing aid" R9-22-201

"HIPAA" R9-22-701

"Home health services" R9-22-201

"Homebound" R9-22-1401

"Hospital" R9-22-101

"In-kind income" R9-22-1420

"Insured entity" R9-22-720

"Intermediate Care Facility for
the Mentally Retarded" or "ICF-MR" 42 USC 1396d(d)

"ICU" R9-22-701

"IHS" R9-22-101

"IHS enrolled" or "enrolled with IHS" R9-22-708

"IMD" or "Institution for Mental Diseases" 42 CFR 435.1010 and ~~R9-22-201~~ R9-22-101

"Income" R9-22-1401 and R9-22-1603

"Indigent" R9-22-1401

"Individual" R9-22-211

"Inmate of a public institution" 42 CFR 435.1010

"Inpatient covered charges" R9-22-712.07

"Interested party" R9-22-101

"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR" 42 U.S.C. 1396d(d)

"Intern and Resident Information System" R9-22-701

"LEEP" R9-22-2001

"Legal representative" R9-22-101

"Level I trauma center" R9-22-2101

"License" or "licensure" R9-22-101

"Licensee" R9-22-1201

"Liquid assets" R9-22-1401

"Mailing date" R9-22-101

"Medical education costs" R9-22-701

"Medical expense deduction" or "MED" R9-22-1401

"Medical record" R9-22-101

"Medical review" R9-22-701

"Medical services" A.R.S. § 36-401

"Medical supplies" ~~R9-22-201~~ R9-22-101

"Medical support" R9-22-1401

"Medically necessary" R9-22-101

"Medicare claim" R9-22-101

"Medicare HMO" R9-22-101

"Member" A.R.S. § 36-2901

"Mental disorder" A.R.S. § 36-501

"Milliman study" R9-22-712.07

"Monthly equivalent" R9-22-1421 and R9-22-1603

"Monthly income" R9-22-1421 and R9-22-1603

"National Standard code sets" R9-22-701

"New hospital" R9-22-701

"NICU" R9-22-701

"Noncontracted Hospital" R9-22-718

"Noncontracting provider" A.R.S. § 36-2901

"Non-FES member" ~~R9-22-201~~ R9-22-101

"Non-IHS Acute Hospital" R9-22-701

"Nonparent caretaker relative" R9-22-1401

"Notice of Findings" R9-22-109

"Nursing facility" or "NF" 42 U.S.C. 1396r(a)

"OBHL" R9-22-1201

"Observation day" R9-22-701

"Occupational therapy" R9-22-201

"Offeror" R9-22-101

"Operating costs" R9-22-701

"Organized health care delivery system" R9-22-701

"Outlier" R9-22-701

"Outpatient hospital service" R9-22-701

"Ownership change" R9-22-701

"Ownership interest" 42 CFR 455.101

"Parent" R9-22-1603

"Partial Care" R9-22-1201

"Participating institution" R9-22-701

"Peer group" R9-22-701

"Peer-reviewed study" R9-22-2001

"Penalty" R9-22-1101

"Pharmaceutical service" R9-22-201

"Physical therapy" R9-22-201

"Physician" R9-22-101

"Physician assistant" R9-22-1201

"Post-stabilization services" R9-22-201 or 42 CFR 422.113

"PPC" R9-22-701

"PPS bed" R9-22-701

"Practitioner" R9-22-101

"Pre-enrollment process" R9-22-1401

"Premium" R9-22-1603

"Prescription" R9-22-101

"Primary care provider or "PCP" R9-22-101

"Primary care provider services" R9-22-201

"Prior authorization" R9-22-101

"Prior period coverage" or "PPC" R9-22-701

"Procedure code" R9-22-701

"Proposal" R9-22-101

"Prospective rates" R9-22-701

"Psychiatrist" R9-22-1201

"Psychologist" R9-22-1201

"Psychosocial rehabilitation services" R9-22-201

"Public hospital" R9-22-701

"Qualified alien" A.R.S. § 36-2903.03

"Qualified behavioral health service provider" R9-22-1201

"Quality management" R9-22-501

"Radiology" R9-22-101

"RBHA" or "Regional Behavioral Health Authority" R9-22-201

"Reason to know" R9-22-1101

"Rebase" R9-22-701

"Referral" R9-22-101

"Rehabilitation services" R9-22-101

"Reinsurance" R9-22-701

"Remittance advice" R9-22-701

"Resident" R9-22-701

"Residual functional deficit" R9-22-201

"Resources" R9-22-1401

"Respiratory therapy" R9-22-201

"Respite" R9-22-1201

"Responsible offeror" R9-22-101

"Responsive offeror" R9-22-101

"Revenue Code" R9-22-701

"Review" R9-22-101

"Review month" R9-22-101

"RFP" R9-22-101

"Rural Contractor" R9-22-718

"Rural Hospital" R9-22-712.07 and R9-22-718

"Scope of services" R9-22-201

"Section 1115 Waiver" A.R.S. § 36-2901

"Service location" R9-22-101

"Service site" R9-22-101

"SOBRA" R9-22-101

"Specialist" R9-22-101

"Specialty facility" R9-22-701

"Speech therapy" R9-22-201

"Spendthrift restriction" R9-22-1401

"Sponsor" R9-22-1401

"Sponsor deemed income" R9-22-1401

"Sponsoring institution" R9-22-701

"Spouse" R9-22-101

"SSA" 42 CFR 1000.10

"SSDI Temporary Medical Coverage" R9-22-1603

"SSI" 42 CFR 435.4

"SSN" R9-22-101

"Stabilize" 42 U.S.C. 1395dd

"Standard of care" R9-22-101

"Sterilization" R9-22-201

"Subcontract" R9-22-101

"Submitted" A.R.S. § 36-2904

"Substance abuse" R9-22-201

"SVES" R9-22-1401

"Therapeutic foster care services" R9-22-1201

"Third-party" R9-22-1001

"Third-party liability" R9-22-1001

"Tier" R9-22-701

"Tiered per diem" R9-22-701

"Title IV-D" R9-22-1401

"Title IV-E" R9-22-1401

"Total Inpatient payments" R9-22-712.07

"Trauma and Emergency Services Fund" A.R.S. § 36-2903.07

"TRBHA" or "Tribal Regional Behavioral Health Authority" R9-22-1201

"Treatment" R9-22-2004

"Tribal Facility" A.R.S. § 36-2981

"Unrecovered trauma center readiness costs" R9-22-2101

"Urban Contractor" R9-22-718

"Urban Hospital" R9-22-718

"USCIS" R9-22-1401

"Utilization management" R9-22-501

"WWHP" R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"Children's Rehabilitative Services" or "CRS" means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"IHS" means Indian Health Service.

"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417(L).

"Non-FES member" means an eligible person who is entitled to full AHCCCS services.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services ~~contingent on the medical necessity of the services.~~ based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. Scope of Services-related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Anticipatory guidance" means a person responsible for a child receives information and guidance of what the person should expect of the child's development and how to help the child stay healthy.

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

~~"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.~~

"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

~~"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.~~

"Emergency behavioral health condition for ~~the~~ a non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

"Emergency behavioral health services for ~~the~~ a non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.

"Emergency medical condition for ~~the~~ a non-FES member" means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

"Emergency medical services for ~~the~~ non-FES member" means services provided for the treatment of an emergency medical condition.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

~~"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.~~

~~"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.~~

~~"Non-FES member" means an eligible person who is entitled to full AHCCCS services.~~

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-202. General Requirements

A. For the purposes of this Article, the following definitions apply:

1. "Authorization" means ~~written or verbal~~ written, verbal, or electronic authorization by:
   a. The Administration for services rendered to a fee-for-service member, or
   b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. ~~A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider or upon authorization by the contractor or the contractor's designee.~~ A member may receive behavioral health services as specified in Article 2 and Article 12.
7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;

b. Services or items furnished gratuitously, and

c. Personal care items except as specified under R9-22-212.

10. Medical or behavioral health services are not covered services if provided to:

a. An inmate of a public institution;

b. A person who is in residence at an institution for the treatment of tuberculosis; or

c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not ~~reimburse services that require~~ provide prior authorization for services unless the provider submits documentation of ~~documents the diagnosis and~~ the medical necessity of the treatment along with the prior authorization request.

D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. A service is not a covered service if provided outside the GSA unless one of the following applies:

1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;

2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;

3. The contractor authorizes placement in a nursing facility located out of the GSA; or

4. Services are provided during prior period coverage.

G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.

J. The restrictions, limitations, and exclusions in this Article do not apply to the following:

1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27; and

2. A contractor electing to provide noncovered services.

a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.

b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for ~~one hundred~~ 100 percent federal financial participation:

1. R9-22-205(A)(8),
2. R9-22-205(B)(4)(f),
3. R9-22-206,
4. R9-22-207,
5. R9-22-212 (C),
6. R9-22-212 (D),
7. R9-22-212 (E)(8),
8. R9-22-215 (C)(2), and
9. R9-22-215 (C)(5).

R9-22-204. Inpatient General Hospital Services

A. A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care unit (NICU);
   c. Intensive care unit (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery and related services;
   f. Routine care; and
   g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).
2. Ancillary services as specified by the Director and included in contract:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescription drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and

h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.

B. The following limitations apply to inpatient general hospital services that are provided by FFS providers.

1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   ~~b. Elective surgery, excluding a voluntary sterilization procedure. Voluntary sterilization procedure does not require prior authorization; and~~
   b. Elective surgery; and
   c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.

3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Voluntary sterilization;
   b. Dialysis shunt placement;
   c. Arteriovenous graft placement for dialysis;
   d. Angioplasties or thrombectomies of dialysis shunts;
   e. Angioplasties or thrombectomies of arteriovenous graft for dialysis;
   f. Hospitalization for vaginal delivery that does not exceed 48 hours;
   g. Hospitalization for cesarean section delivery that does not exceed 96 hours; and
   h. Other services identified by the Administration through the Provider Participation Agreement.

~~2.~~4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
   ~~a. A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.~~
   ~~b. Failure of the provider to obtain prior authorization is cause for denial of a claim.~~

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.

2. Definitions.
    a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS~~,~~ or a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
    b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
    a. Emergency medical services. ~~Prior authorization is not required for emergency medical services for non-FES members.~~ A provider is not required to obtain prior authorization for emergency medical services.
    b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
5. Prohibition against denial of payment. Neither the ~~The~~ Administration ~~and~~ nor a contractor shall; ~~not limit or deny payment for emergency medical services for the following reasons:~~
    ~~a. On the basis of lists of diagnoses or symptoms,~~
    ~~b. Prior authorization was not obtained, or~~
    ~~c. The provider does not have a subcontract.~~
    a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
    b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
    c. Deny or limit payment because the provider does not have a subcontract.
6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
    a. The claim was not a clean claim;
    b. The claim was not submitted timely; and
    c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.

1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.

2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
3. Contractor notification ~~Notification~~. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.

C. Post-stabilization services for non-FES members enrolled with a contractor.

1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
    a. The contractor does not respond to a request for prior authorization within one hour;
    b. The contractor authorized to give the prior authorization cannot be contacted; or
    c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
        i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
        ii. A contractor physician assumes responsibility for the member's care through transfer;
        iii. The contractor's representative and the treating physician reach agreement concerning the member's care; or
        iv. The member is discharged.
5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.

1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
    a. Members enrolled with a contractor.
        i. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor, from one of the following time periods, whichever comes first:
            (1) The date on which the member becomes a behavioral health recipient; or
            (2) The seventy-third hour after admission for inpatient emergency behavioral health services.
        ii. Contractors. Contractors are responsible for providing inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with a contractor and are not behavioral health recipients, for the first 72 hours after admission.
    b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-

FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-102.

6. Prior authorization.
   a. Emergency behavioral health services. ~~Emergency behavioral health services do not require prior authorization.~~ A provider is not required to obtain prior authorization for emergency behavioral health services.
   b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
7. Prohibition against denial of payment. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
   a. On the basis of lists of diagnoses or symptoms;
   b. Prior authorization was not obtained;
   c. The provider does not have a contract;
   d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
   e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
8. Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
   a. The claim was not a clean claim,
   b. The claim was not submitted timely, or
   c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
9. Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
10. Behavioral health evaluation. An emergency behavioral health evaluation is covered as an emergency behavioral health service for a non-FES member under this Section if:
    a. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse; and
    b. Provided by a qualified provider who is:
       i. A behavioral health medical practitioner as defined in R9-22-112, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, and a licensed marriage and family therapist; or

ii. An ADHS/DBHS-contracted provider.

11. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

B. Post-stabilization requirements for non-FES members.

1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
   a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
   b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
   c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
      i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
      ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
      iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
      iv. The member is discharged.

R9-22-211. Transportation Services

A. Emergency ambulance services.

1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
    a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and
    b. If no other appropriate means of transportation is available.
2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
    a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
    b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
    c. No prior authorization is required for reimbursement of these transports.
3. The member's medical condition at the time of transport determines whether the transport is medically necessary.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to ~~obtain prior authorization~~ provide notification is cause for denial.
5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim ~~which~~ that justifies the service.

B. The Administration or a contractor covers air ambulance services only if ~~one or more of the criteria~~ at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2) ~~(2)~~, or the criterion in subsection (B)(3) ~~(3)~~ is met. The criteria are:

1. The air ambulance transport is initiated at the request of:
    a. An emergency response unit;
    b. A law enforcement official;
    c. A clinic or hospital medical staff member; or
    d. A physician or practitioner; and
2. The point of pickup:
    a. Is inaccessible by ground ambulance; or
    b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice; or
3. The medical condition of the member requires immediate intervention ~~:~~
    ~~a.~~ ~~Intervention~~ from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition~~, or~~.
    ~~b. Ground ambulance service will not suffice for the factors listed in subsection (B)(2).~~

C. Coverage of medically ~~Medically~~ necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.

1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.

D. For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:

1. The transportation services are authorized by the Administration or the member's contractor or designee;
2. The individual is an AHCCCS registered provider; and
3. No other means of appropriate transportation is available.

E. The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved ~~and prior authorized~~ health care service site outside of the member's service area or county of residence.

F. The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:

1. A family member accompanying a member if:
   a. The member is traveling to or returning from an approved ~~and prior authorized~~ health care service site outside of the member's service area or county of residence; and
   b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
2. An escort who is not a family member as follows:
   a. If the member is travelling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence; ~~and~~
   b. If the escort services are authorized by the Administration or the member's contractor or designee~~.~~<u>; and</u>
   c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.

G. A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:

1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system <u>when the distance traveled exceeds 100 miles (whether one way or round trip)</u>; and
2. All meals, lodging, and services of an escort accompanying the member under this Section.

H. A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

R9-22-215. Other Medical Professional Services

A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting ~~as follows~~:

1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
   a. Medications;
   b. Supplies;
   c. Devices; and
   d. Surgical procedures.
3. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Sterilization; and
   c. Natural family planning education or referral;
4. Midwifery services provided by a certified nurse practitioner in midwifery;
5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services ~~when medically necessary and prior authorized~~;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
12. Inpatient chemotherapy; and
13. Outpatient chemotherapy.

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11)~~.~~; except for:

1. Voluntary sterilization,
2. Dialysis shunt placement,
3. Arteriovenous graft placement for dialysis,
4. Angioplasties or thrombectomies of dialysis shunts,
5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis,
6. Eye surgery for the treatment of diabetic retinopathy,
7. Eye surgery for the treatment of glaucoma,
8. Eye surgery for the treatment of macular degeneration,

9. Home health visits following an acute hospitalization (limited up to five visits),
10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization,
11. Physical therapy subject to the limitation in subsection (C),
12. Facility services related to wound debridement,
13. Apnea management and training for premature babies up to the age of one, and
14. Other services identified by the Administration through the Provider Participation Agreement.

C. The following ~~services are excluded as~~ are not covered services:

1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling;
4. Services or items furnished solely for cosmetic purposes;
5. Services provided by a podiatrist; or
6. More than 15 outpatient physical therapy visits per ~~contract year~~ benefit year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.

R9-22-217. Services Included in the Federal Emergency Services Program

A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

B. Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for an FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in ~~his~~ the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:

1. Placing the ~~patient's~~ member's health in serious jeopardy, or
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered ~~and timely notification as specified in subsection (E) is given~~. The Administration shall determine whether an emergency condition exists on a case-by-case basis.

D. Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).

~~**E.** Notification. A provider shall notify the Administration no later than 72 hours after a FES member receiving emergency medical or behavioral health services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-703. Payments by the Administration

A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

B. Timely submission of claims.

1. Under A.R.S. § 36-2904, the Administration shall deem a paper or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
    a. Place a date stamp on the face of the claim,
    b. Assign a system-generated claim reference number, or
    c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    b. Six months from the date of eligibility posting.
3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
    a. Twelve months from the date of service or for an inpatient hospital claim, twelve months from the date of discharge; or
    b. Twelve months from the date of eligibility posting.
4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.

C. Claims processing.

1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
    a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.

b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.

c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.

3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim under this Article.

D. Prior authorization.

1. An AHCCCS-registered provider shall:
   a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
   b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
   c. Make records available for review by the Administration upon request.
2. ~~The Administration shall reduce payment of or deny claims, if an AHCCCS registered provider fails to obtain prior authorization or notify the Administration under Article 2 of this Chapter and this Article.~~
   The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
3. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the Administration shall adjust the claim to pay for the cost of the appropriate level of care.

E. Review of claims and coverage for hospital supplies.

1. The Administration may conduct prepayment and postpayment review of any claims, including but not limited to hospital claims.
2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor or disposable razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Shampoo,

l. Powder,
m. Lotion,
n. Comb, and
o. Patient gown.

3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.
4. The Administration shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.

F. Overpayment for AHCCCS services.

1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
3. The Administration shall document any recoupment of an overpayment on a remittance advice.
4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.

R9-22-712. Reimbursement: General

A. Inpatient and outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

B. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. ~~The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.~~

The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.

F. Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.
3. A denied claim is considered adjudicated on the date the claim is denied.
4. Claims that are denied and are resubmitted are assigned new receipt dates.
5. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
    a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
    b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services

provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.

5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) by applying the following formula:

CCR*[1.047/(1+ % increase)]

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services