NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected **Rulemaking Action**

R9-31-201	Amend
R9-31-204	Amend
R9-31-215	Amend
Article 16	Amend
R9-31-1601	Amend
R9-31-1602	Repeal
R9-31-1603	Repeal
R9-31-1604	Repeal
R9-31-1605	Repeal
R9-31-1606	Repeal
R9-31-1607	Repeal
R9-31-1608	Repeal
R9-31-1609	Repeal
R9-31-1610	Repeal
R9-31-1611	Repeal
R9-31-1612	Repeal
R9-31-1613	Repeal
R9-31-1614	Repeal
R9-31-1615	Repeal
R9-31-1622	Repeal
R9-31-1625	Repeal

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. 514, April 8, 2011

Notice of Proposed Rulemaking: 17 A.A.R. 501, 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
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Phoenix, AZ 85034

Telephone: (602) 417-4693

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

The proposed rules will eliminate the requirement for obtaining 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. Article 16 rules are being repealed because the rules were found to be duplicative of many rules in Chapter 22, Article 2. The Administration believes that a cross reference to Article 2 makes the rules more concise and manageable. References to "Native American" are being replaced by "American Indian" because the appropriate term and culturally correct phrase is "American Indian".

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 for Federal Emergency Service (FES) members since Federal regulations and state plan prohibit prior authorization for emergency services. The reference to concurrent review in rule is therefore 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 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 2. SCOPE OF SERVICES

Section

ARTICLE 16. SERVICES FOR ~~NATIVE AMERICANS~~ AMERICAN INDIANS

Section

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.

B. Scope of services for ~~Native American~~ American Indian fee-for-service members is under Article 16 of this Chapter.

C. A contractor or RBHA shall provide behavioral health services under Article 12 and Article 16.

D. 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. The Administration or a contractor may waive the covered services referral requirements of this Article.
3. Except as authorized by a contractor, a primary care provider, practitioner, or 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.
4. 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.
5. ~~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 9 A.A.C. 22 Article 2 and 9 A.A.C. 22 Article 12.
6. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
8. 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 in R9-31-212.
9. Medical or behavioral health services are not covered if provided to:
    a. An inmate of a public institution;
    b. A person who is a resident of an institution for the treatment of tuberculosis; or
    c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

E. ~~The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.~~

The Administration or a contractor may deny payment if a provider fails to obtain prior authorization as specified in this Article and Article 7 of this Chapter for non-emergency services. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside of the GSA only if one of the following applies:

1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If the member is referred outside of the GSA to receive an authorized medically necessary service, a 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; or
3. The contractor authorizes placement in a nursing facility located outside of the GSA;

H. 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.

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

J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services.

1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
2. 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.

R9-31-204. Inpatient General Hospital Services

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, 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 under 9 A.A.C. 31, Article 12.
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 not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.

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

R9-31-215. 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, medication, 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; and
   b. Natural family planning education or referral;
4. Midwifery services provided by a nurse practitioner certified in midwifery;
5. Podiatry services if ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services in A.R.S. § 36-2989;

9. Private or special duty nursing services ~~if medically necessary and prior authorized~~;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;
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;
13. Outpatient chemotherapy; and
14. Hospice care under R9-22-213

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (A)(11) and (A)(14); except for:

1. Dialysis shunt placement;
2. Arteriovenous graft placement for dialysis;
3. Angioplasties or thrombectomies of dialysis shunts;
4. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
5. Eye surgery for the treatment of diabetic retinopathy;
6. Eye surgery for the treatment of glaucoma;
7. Eye surgery for the treatment of macular degeneration;
8. Home health visits following an acute hospitalization (limited up to five visits);
9. 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);
10. Physical therapy subject to the limitation in subsection R9-22-215 (C);
11. Facility services related to wound debridement.;
12. Apnea management and training for premature babies up to the age of one; and
13. Other services identified by the Administration through the Provider Participation Agreement.

ARTICLE 16. SERVICES FOR ~~NATIVE AMERICANS~~ AMERICAN INDIANS

R9-31-1601. General Requirements

A. ~~A Native American~~ An American Indian who is a member may receive:

1. Covered acute care services specified in this Chapter from:
   a. Indian Health Service (IHS) under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, ~~or~~
   c. A contractor under A.R.S. § 36-2901~~.~~, or
   d. An AHCCCS registered provider.

2. Covered behavioral health care services as specified in this Chapter from:
   a. IHS under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,

b. A Tribal Facility under A.R.S. § 36-2982, or

c. A RBHA or TRBHA.

B. IHS, a Tribal facility, or a referred provider shall meet the requirements in this Chapter and A.A.C. Chapter 22, Article 2, and A.A.C. Chapter 22, Article 7 to receive reimbursement for AHCCCS-covered services. ~~The following sections of~~ Title 9 A.A.C. Chapter 22, Article 2 and Article 7 are applicable to reimbursement for AHCCCS-covered services provided to ~~a Native American~~ an American Indian member under the KidsCare program, except that the term "IHS", "Tribal facility", or "referred provider" is substituted for "provider"~~:~~.

~~1. Scope of the Administration's Liability, R9-22-701.10;~~

~~2. Charges to Members, R9-22-702;~~

~~3. Prior authorization, R9-22-703(D);~~

~~4. Claims Review, R9-22-703(E);~~

~~5. Payments by the Administration, R9-22-703;~~

~~6. Payments for Services Provided to Eligible Native Americans, R9-22-708;~~

~~7. Payments to Providers, R9-22-714; and~~

~~8. Specialty Contracts, R9-22-712(G)(3), R9-22-712.01(10).~~

R9-31-1602. ~~General Requirements for Scope of Services~~ Repealed

~~**A.** In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:~~

~~1. Under A.R.S. § 36-2989, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services are provided under referral from the IHS or a Tribal Facility provider.~~

~~2. If IHS cannot provide a covered service due to in the appropriation of funds by Congress, the obligation to allocate IHS program resources nationwide, or a fundamental shift in the manner of providing health services to Native Americans on a national basis then a member shall be referred to a non IHS provider or a non IHS facility for the service.~~

~~**B.** As specified in A.R.S. § 36-2989, covered services rendered to a member are provided within the service area of the IHS or a Tribal Facility except when:~~

~~1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services,~~

~~2. A covered service that is medically necessary for a member is not available within the service area, or~~

~~3. A member is placed in an NF located out of the service area.~~

~~**C.** If a member requests the provision of service that is not covered or not authorized by the IHS or Tribal Facility, an AHCCCS registered provider may provide the service under the following conditions:~~

~~1. IHS or a Tribal Facility shall prepare and provide the member with a document that lists the requested services and the estimated cost of each service; and~~

2. ~~The member signs a document prior to the provision of services indicating that the member understands the services and accepts the responsibility for payment.~~

D. ~~Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.~~

R9-31-1603. ~~Inpatient General Hospital Services~~ Repealed

A. ~~A fee-for-service provider or non-contracting provider shall provide the following 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 (NICU);~~
   c. ~~Intensive care (ICU);~~
   d. ~~Surgery, including surgery room and recovery room;~~
   e. ~~Nursery;~~
   f. ~~Routine care; and~~
   g. ~~Emergency behavioral services under 9 A.A.C. 31, Article 12;~~
2. ~~The following ancillary services including:~~
   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 which are customarily reimbursed as ancillary services.~~

B. ~~The following limitations apply to inpatient general hospital services that are provided by a FFS provider:~~

1. ~~A provider 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. A voluntary sterilization procedure does not require prior authorization; and~~
   c. ~~A service or items provided to reconstruct or improve personal appearance after an illness or injury.~~
2. ~~The Administration may perform concurrent review for hospitalizations to determine whether there is medical necessity for the hospitalization.~~

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.

R9-31-1604. Physician and Primary Care Physician and Practitioner Services Repealed

A. Primary care services shall be furnished by a physician or a primary care practitioner. Primary care services may be provided in an inpatient or outpatient setting and shall include:

1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Prescriptions for medications and medically necessary supplies and equipment,
4. Referrals to a specialist or other health care professional when medically necessary as specified in A.R.S. § 36-2989,
5. Patient education,
6. Home visits when determined medically necessary,
7. Covered immunizations, and
8. Covered preventive health services.

B. As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgeries for a member referred out of the IHS or a Tribal Facility. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery.

C. The following limitations and exclusions apply to physician and practitioner services and primary care provider services for a member referred out of the IHS or a Tribal Facility:

1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given;
2. If a physical examination is performed with the primary intent to accomplish one or more of the objectives listed in subsection (A), it may be covered by the IHS or a Tribal Facility except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot's examination (FAA),
   e. Disability certification for establishing any kind of periodic payments,
   f. Evaluation for establishing third-party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
3. The following services shall be excluded from Title XXI coverage:

a. ~~Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;~~

b. ~~Services or items furnished solely for cosmetic purposes;~~

c. ~~Hysterectomies, unless determined to be medically necessary;~~

d. ~~Abortion counseling or abortion except according to federal law;~~

e. ~~Chiropractic services; and~~

f. ~~Licensed midwife service for prenatal care and home births.~~

R9-31-1605. ~~Organ and Tissue Transplantation Services~~ Repealed

A. ~~The following organ and tissue transplantation services are covered for a member as specified in A.R.S. § 36-2989 if prior authorized by the Administration:~~

1. ~~Kidney transplantation,~~
2. ~~Simultaneous Kidney/Pancreas transplant,~~
3. ~~Cornea transplantation,~~
4. ~~Heart transplantation,~~
5. ~~Liver transplantation,~~
6. ~~Autologous and allogenic bone marrow transplantation,~~
7. ~~Lung transplantation,~~
8. ~~Heart-lung transplantation, and~~
9. ~~Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met.~~

B. ~~Immunosuppressant medications, chemotherapy, and other related services provided in an IHS, a Tribal Facility, or by a referral provider do not need to be prior authorized.~~

R9-31-1606. ~~Dental Services~~ Repealed

~~Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.~~

R9-31-1607. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed

~~As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services may be covered services if:~~

1. ~~Prescribed for a member by an IHS, a Tribal Facility care provider or a dentist, or if prescribed by a physician or a practitioner upon referral from the IHS, a Tribal Facility provider or a dentist;~~
2. ~~Provided in a hospital, a clinic, a physician office, or other health care facility by IHS or a Tribal Facility provider; or~~
3. ~~Provided by an IHS or a Tribal Facility provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in a provider's license or certification.~~

R9-31-1608. ~~Pharmaceutical Services~~ Repealed

A. ~~Pharmaceutical services may be provided by the IHS, a Tribal Facility, or upon referral from an IHS or a Tribal Facility provider.~~

~~**B.** As specified in A.R.S. § 36-2989, pharmaceutical services are covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.~~

~~**C.** The following limitations apply to pharmaceutical services:~~

~~1. A medication personally dispensed by a physician or a dentist, or a practitioner within the individual's scope of practice, is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.~~

~~2. A prescription or refill in excess of 100 unit doses is not covered. A prescription or refill in excess of a 30 day supply is not covered unless specified in subsection (C)(3).~~

~~3. A prescription or refill in excess of a 30 day supply is covered if:~~

~~a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100 day supply or 100 unit doses, whichever is greater.~~

~~b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 100 day supply or 100 unit doses, whichever is greater.~~

~~c. The medication is prescribed for contraception and the prescription is limited to no more than a 100 day supply.~~

~~4. An over the counter medication in place of a covered prescription medication is covered only if the over the counter medication is appropriate, equally effective, safe, and is less costly than the covered prescription medication.~~

~~**D.** The IHS or a Tribal Facility shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being.~~

R9-31-1609. ~~Emergency Services~~ Repealed

~~Emergency medical services provided by the IHS, a Tribal Facility, or a referral provider outside the service area shall be provided based on the prudent layperson standard to a member by the IHS or a Tribal Facility provider registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.~~

R9-31-1610. ~~Transportation Services~~ Repealed

~~The Administration shall provide transportation services under A.A.C. R9-22-211.~~

R9-31-1611. ~~Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies~~ Repealed

~~Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with the requirements of this Chapter and A.A.C. R9-22-212. For purposes of this Section, where the phrase "AHCCCS services" is used in R9-22-212, it is replaced with the phrase "Title XXI services." Where the term "provider" or "contractor" is used, it is replaced with the phrase "IHS or Tribal facility."~~

R9-31-1612. ~~Health Risk Assessment and Screening Services~~ Repealed

~~**A.** As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:~~

~~1. Screening services, including:~~

~~a. Comprehensive health, behavioral health, and developmental histories;~~

~~b. Comprehensive unclothed physical examination;~~

~~c. Appropriate immunizations according to age and health history;~~

~~d. Health education, including anticipatory guidance; and~~

~~e. Laboratory tests.~~

~~2. Vision services including:~~

~~a. Diagnosis and treatment for defects in vision.~~

~~b. Eye examinations for the provision of prescriptive lenses, and~~

~~c. Provision of prescriptive lenses.~~

~~3. Hearing services, including:~~

~~a. Diagnosis and treatment for defects in hearing,~~

~~b. Testing to determine hearing impairment, and~~

~~c. Provision of hearing aids.~~

~~**B.** Providers of services shall meet the following standards:~~

~~1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist;~~

~~2. Perform tests and examinations under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;~~

~~3. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care; and~~

~~4. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.~~

~~**C.** The IHS or a Tribal Facility shall meet additional conditions for a member as stated in the Intergovernmental Agreement between the Administration and IHS.~~

~~**D.** The IHS or a Tribal Facility provider shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.~~

R9-31-1613.~~ Other Medical Professional Services~~ Repealed

~~**A.** The following medical professional services are covered services if a member receives these services in an inpatient, an outpatient, or an 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, medication, 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; and~~
    b. ~~Natural family planning education or referral;~~
4. ~~Midwife services provided by a certified nurse practitioner;~~
5. ~~Podiatry services if ordered by an IHS or a Tribal Facility provider;~~
6. ~~Respiratory therapy;~~
7. ~~Ambulatory and outpatient surgery facilities services;~~
8. ~~Home health services;~~
9. ~~Private or special duty nursing services if medically necessary and prior authorized;~~
10. ~~Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;~~
11. ~~Total parenteral nutrition services which is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;~~
12. ~~Hospice care under R9-22-213,~~
13. ~~Inpatient chemotherapy, and~~
14. ~~Outpatient chemotherapy.~~

B. ~~The Administration shall prior authorize services in subsections (A)(4) through (12) for a member referred out of the IHS or a Tribal Facility service area.~~

R9-31-1614. ~~NF, Alternative HCBS Setting, or HCBS~~ Repealed

A. ~~Services provided in a NF, including room and board, an alternative HCBS setting, or a HCBS as defined under A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.~~

B. ~~Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:~~

1. ~~Nursing services, including:~~
    a. ~~Administration of medication;~~
    b. ~~Tube feeding;~~
    c. ~~Personal care services, including but not limited to assistance with bathing and grooming;~~
    d. ~~Routine testing of vital signs; and~~
    e. ~~Maintenance of catheter.~~
2. ~~Basic patient care equipment and sickroom supplies, including:~~
    a. ~~First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over the counter remedies;~~
    b. ~~Bathing and grooming supplies;~~
    c. ~~Identification device;~~
    d. ~~Skin lotion;~~

e. ~~Medication cup;~~

f. ~~Alcohol wipes, cotton balls, and cotton rolls;~~

g. ~~Rubber gloves (non-sterile);~~

h. ~~Laxatives;~~

i. ~~Bed and accessories;~~

j. ~~Thermometer;~~

k. ~~Ice bag;~~

l. ~~Rubber sheeting;~~

m. ~~Passive restraints;~~

n. ~~Glycerin swabs;~~

o. ~~Facial tissue;~~

p. ~~Enemas;~~

q. ~~Heating pad; and~~

r. ~~Diapers.~~

3. ~~Dietary services including preparing and administering special diets or adaptive tools for eating;~~

4. ~~Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;~~

5. ~~Physical therapy; and~~

6. ~~Assistive device or non-customized DME.~~

C. ~~The Administration shall prior authorize each NF admission outside the IHS or a Tribal Facility's service area.~~

R9-31-1615. ~~**Eligibility and Enrollment**~~ **Repealed**

~~The eligibility and enrollment provisions specified in 9 A.A.C. 31, Article 3 apply to a Native American who elects to receive services through the IHS or a Tribal Facility.~~

R9-31-1622. ~~**The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care**~~ **Repealed**

A. ~~Expenses for an emergency or acute medical health condition of a member are reimbursed only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of this Chapter and A.R.S. § 36-2989. This Section only applies to those noncontracting hospitals outside the IHS or Tribal Facility network.~~

B. ~~Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the discharge date or transfer under R9-31-705.~~

C. ~~If a member refuses transfer from a noncontracting provider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration is not liable for any costs incurred after the date of refusal if:~~

1. ~~After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and~~

2. ~~A member is provided and signs a written statement, before the date the member is liable for payment informing a member of the medical and financial consequences of refusing to transfer. If a member refuses~~

~~to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.~~

R9-31-1625. ~~**Behavioral Health Services**~~ **Repealed**

~~A.~~ ~~The IHS, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is a member.~~

~~B.~~ ~~The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from one entity to another becomes necessary.~~

~~C.~~ ~~The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:~~

~~1. A TRBHA if one is operating in a service area, or~~

~~2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.~~

~~D.~~ ~~If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall refer the member to a RBHA or a TRBHA.~~

~~E.~~ ~~If a member is enrolled with a contractor and is not enrolled with a TRBHA or a RBHA, the contractor is responsible for the provision of emergency behavioral health services for up to three days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA for continued service authorization and any needed additional services.~~

~~F.~~ ~~The provider shall obtain prior authorization for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.~~

~~G.~~ ~~A provider shall comply with the requirements specified in subsections (B) and (C). If a provider fails to comply, payment is denied, or if paid, is recouped by the Administration.~~

~~H.~~ ~~A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.~~