

NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 16. ALLOPATHIC BOARD OF MEDICAL EXAMINERS

PREAMBLE

- | <u>1. Sections Affected</u> | <u>Rulemaking Action</u> |
|-----------------------------|--------------------------|
| R4-16-201 | Amend |
| R4-16-202 | Amend |
| R4-16-203 | Amend |
| R4-16-204 | Amend |
| R4-16-205 | Amend |
- 2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statutes: A.R.S. §§ 32-1403(A)(8) and 32-1404(D)
Implementing statute: A.R.S. § 32-1491(E)
- 3. The effective date of the rules:**
May 9, 2002
- 4. A list of all previous notices appearing in the Register addressing the proposed rule:**
Notice of Rulemaking Docket Opening: 7 A.A.R. 3046, July 13, 2001
Notice of Proposed Rulemaking: 7 A.A.R. 5235, November 23, 2001
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Dominick Spatafora, Legislative and Regulatory Affairs Director
Address: Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258
Telephone: (480) 551-2712
Fax: (480) 551-2704
- 6. An explanation of the rule, including the agency's reasons for initiating the rule:**
The Arizona Board of Medical Examiners (Board) is created to protect the public from unlawful, incompetent, unqualified, impaired, or unprofessional practitioners of allopathic medicine (A.R.S. § 32-1403(A)). A.R.S. § 32-1403(A)(8) authorizes the Board to make rules to regulate the practice of medicine, including qualifications of physicians. A.R.S. § 32-1491(E) requires the Board to adopt dispensing rules that are consistent with Chapter 18 of Arizona Revised Statutes.
These rules cover the dispensing of drugs by physicians. Specifically, the rules address registration and renewal of drug dispensing registration, packaging and inventory, prescribing and dispensing requirements, recordkeeping and shortage reporting, and inspections. The Board is amending these rules to be consistent with current rulewriting standards and to reflect recent statutory changes. The need for these amendments was identified during the five-year review process in September 2000.
- 7. A reference to any study that the agency relied on in its evaluation of or jurisdiction for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
None

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 rule has a minimal financial impact. The Arizona Board of Medical Examiners will bear a minimal cost for writing the rule and fulfilling requirements imposed by the Governor's Regulatory Review Council and the Secretary of State's Office, and for public comments from the regulated community and interested parties regarding the rulemaking.

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

Four changes were made to this rulemaking. First, both R4-16-201 subsections (B) and (C) were changed to maintain a yearly renewal for dispensing certificates. The Board decided that there are too many administrative hurdles involved with moving to a biennial renewal. Second, in the last sentence of R4-16-201(C) the word "register" was changed to "re-register" to conform it to the rest of the subsection. Third, it was discovered that R4-16-202(E)(6) is inconsistent with current statute. Therefore, the subsection was amended to clarify that the signature of a physician must be written next to each entry on a dispensing log. Fourth, R4-16-201(A)(3) and (4) were both removed from this rulemaking. Initially the Board wanted to allow group practices to designate at least one physician as the responsible party for ordering and maintaining controlled substances at each practice location. It has been since discovered that statute mandates that each physician must be responsible for their own actions at all points in the dispensing process. Therefore, the newly proposed language was removed in this final rulemaking. In addition to the changes listed above, other minor technical changes were made throughout the rules to improve clarity, grammar, and consistency as suggested by the G.R.R.C. staff.

11. A summary of the principal comments and the agency response to them:

No comments were received.

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

None

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

None

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

No

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 16. ALLOPATHIC BOARD OF MEDICAL EXAMINERS

ARTICLE 2. DISPENSING OF DRUGS

Section

- R4-16-201. Registration and Renewal
- R4-16-202. Packaging and Inventory; Exception
- R4-16-203. Prescribing and Dispensing Requirements
- R4-16-204. Recordkeeping and Reporting Shortages
- R4-16-205. Inspections; Denial and Revocation

ARTICLE 2. DISPENSING OF DRUGS

R4-16-201. Registration and Renewal

- A. A physician who wishes to dispense a controlled substance as defined in A.R.S. § 32-1901(12), a prescription-only drug as defined in A.R.S. § 32-1901(65), or a prescription-only device as defined in A.R.S. § 32-1901(64) ~~substances and prescription-only drugs and devices~~ shall be currently licensed to practice medicine in the state of Arizona and shall provide to the Board the following:
 - 1. A completed form for registration ~~form, furnished by the Board, that~~ which includes the following information:
 - a. The physician's name, license number, and field of practice;
 - b. A ~~list listing~~ of the types of drugs and devices the physician ~~will desire to dispense including prescription-only and controlled substances;~~ and
 - c. The location or locations where the physician ~~will desire to dispense~~ a controlled substance, a prescription-only drug, or a prescription-only device.

Arizona Administrative Register
Notices of Final Rulemaking

2. A copy of the physician's current Drug Enforcement Administration Certificate of Registration for each dispensing location from which for each dispensing location from which the physician will desires to dispense a controlled substance, substances.
 3. The fees required in A.R.S. § 32-1436, statutorily required fee.
- B.** A physician shall renew a registration to dispense a controlled substance, a prescription-only drug, or a prescription-only device drugs and devices by complying with the requirements set forth in subsection (A) on or before June 30 of each year. ~~When~~ If a physician has made timely and complete application for the renewal of a registration, the physician may continue to dispense until the Board approves or denies the renewal application. ~~application has been approved or denied by the board.~~
- C.** If the completed annual renewal form, all required ~~documentation~~ documentation, and the ~~correct~~ fee are not received in the Board's office on or before June 30, the physician shall not dispense any controlled substances, prescription-only drugs, or prescription-only devices drugs and devices until re-registered, newly registered. The physician shall re-register by filing for initial registration ~~pursuant to~~ under subsection (A) and shall not dispense a controlled substance, a prescription-only drug, or a prescription-only device drugs and devices until receipt of a the re-registration, new registration.

R4-16-202. Packaging and Inventory; Exception

- A.** A physician shall dispense all controlled substances and prescription-only drugs in prepackaged containers or in ~~light resistant~~ light-resistant containers with a consumer safety ~~cap~~ caps, that comply with standards specified in the official compendium as defined in A.R.S. § 32-1901(49) and state and federal law, unless a patient or a patient's representative requests a non-safety cap.
- B.** All controlled substances and prescription-only drugs dispensed shall be labeled with the following information:
1. The physician's name, address, and telephone number;
 2. The date the controlled substance and prescription-only drug is dispensed ~~and its expiration date;~~
 3. The patient's name; ~~and~~
 4. The ~~name, form, name of the manufacturer and strength of the drug,~~ controlled substance and prescription-only drug name, strength, and dosage, form, name of manufacturer, the quantity dispensed, directions for its use, and any cautionary statement necessary for the safe and effective use of the controlled substance and prescription-only drug; and drug.
 5. A beyond-use-date not to exceed one year from the date of dispensing or the manufacturer's expiration date if less than one year.
- C.** A physician shall secure all controlled substances in a locked cabinet or room and shall control access to the cabinet or room by a written procedure ~~which that includes, shall include,~~ at a minimum, designation of the persons who have access to the cabinet or room and procedures for recording requests for access to the cabinet or room, drugs. This written procedure shall be made available on demand to the Board or its authorized representatives for inspection or copying. Prescription-only ~~medications~~ drugs shall be stored so as not to be accessible to patients.
- D.** Controlled substances and prescription-only drugs ~~Drugs~~ not requiring refrigeration shall be maintained in an area where the temperature does not exceed 85° F.
- E.** A physician shall maintain an ongoing dispensing log for all controlled substances and the prescription-only ~~medications~~ drug nalbuphine hydrochloride (Nubain) ~~and butorphanol tartrate (Stadol)~~ dispensed by the physician. ~~which includes separate inventory sheets for each controlled substance, nalbuphine hydrochloride, and butorphanol tartrate.~~ The heading of a dispensing log shall include the following: following information:
1. A separate inventory sheet for each controlled substance and prescription-only drug;
 - ~~1-2.~~ The date the drug is dispensed;
 - ~~2-3.~~ The patient's name;
 - ~~3-4.~~ The name, dosage, form, name of the manufacturer and strength of the drug; controlled substance and prescription-only drug name, strength, dosage, form, and name of the manufacturer;
 - ~~4-5.~~ The number of dosage units dispensed;
 - ~~5-6.~~ A running total of medication each controlled substance and prescription-only drug dispensed; and
 - ~~6-7.~~ The signature of the physician or the person authorized by the physician who dispensed the medication, written next to each entry.
- F.** A physician may use a computer to maintain The the dispensing log required in subsection (E) may be maintained on computer provided that if the log is quickly accessible through either on-screen viewing or printing of a copy.
- G.** This Section does section shall not apply to a prepackaged prepackaged, manufacturer sample samples of drugs a controlled substance and prescription-only drug, unless otherwise provided by federal law.

R4-16-203. Prescribing and Dispensing Requirements

- A.** A physician shall record on the patient's medical record the name, strength, dosage, and form, and strength of the controlled substance, prescription-only drug, or prescription-only device drug or device dispensed, the quantity or volume dispensed, the date the controlled substance, prescription-only drug, or prescription-only device drug or device is dis-

Arizona Administrative Register
Notices of Final Rulemaking

pensed, the medical reasons for dispensing the controlled substance, prescription-only drug, or prescription-only device, drug or device, and the number of refills authorized.

- B.** Before dispensing a controlled substance, prescription-only drug, or prescription-only device ~~Prior to delivery to a the patient, a physician shall review the prepared controlled substance, prescription-only drug, or prescription-only device drugs and devices to ensure their that: compliance with the prescription, and, additionally, ensure that the patient has been informed of the name of the drug or device, directions for its use, precautions, and storage requirements.~~
1. The container label and contents comply with the prescription, and
 2. The patient is informed of the name of the controlled substance, prescription-only drug, or prescription-only device, directions for use, precautions, and storage requirements.
- C.** A physician shall purchase all dispensed controlled substances, prescription-only drugs, or prescription-only devices ~~drugs and devices~~ from a manufacturer or distributor approved by the United States Food and Drug Administration, or a pharmacy holding a current, ~~valid~~ permit from the Arizona Board of Pharmacy.
- D.** The person who prepares a controlled substance, prescription-only drug, or prescription-only device ~~drugs and devices~~ for dispensing shall countersign and date the original prescription form for the controlled substance, prescription-only drug, or prescription-only device, drugs and devices.
- E.** For purposes of this ~~Article, article,~~ “dispensing” means the delivery of a controlled substance, a prescription-only drug, or a prescription-only device, drug or device to a patient for use outside the physician’s office.

R4-16-204. Recordkeeping and Reporting Shortages

- A.** A physician who dispenses a controlled substance or prescription-only drug shall ensure that ~~an All~~ original prescription ~~prescription orders~~ dispensed from the a physician’s office ~~shall be is~~ dated, consecutively numbered in the order in which ~~they were~~ it is originally dispensed, and filed separately from the patient medical records. ~~Original prescription orders for Schedule II drugs or other controlled substances shall be maintained separately from other prescription orders. A physi-~~ cian shall ensure that an original prescription be maintained in three separate files, as follows:
1. Schedule II controlled substances;
 2. Schedule III, IV, and V controlled substances; and
 3. Prescription-only drugs.
- B.** ~~A physician shall maintain drug purchase orders and invoices for controlled substances, nalbuphine hydrochloride and butorphanol tartrate which are received, and original prescription orders for all drugs for a period of three years from the date of the order. Dispensing logs and destruction records shall also be maintained for three years. A physician shall ensure that purchase orders and invoices are maintained for all controlled substances and prescription-only drugs dispensed for profit and not for profit for three years from the date of the purchase order or invoice. Purchase orders and invoices shall be maintained in three separate files as follows:~~
1. Schedule II controlled substances only;
 2. Schedule III, IV, and V controlled substances and nalbuphine; and
 3. All other prescription-only drugs.
- C.** A physician who ~~discovers a theft or loss of a controlled substance or a dangerous drug, as defined in A.R.S. § 13-3401, determines that drugs have been illegally removed from the physician’s office, or that a drug shortage exists in controlled substances maintained for dispensing, shall; immediately notify a local law enforcement agency and thereafter, provide that agency with a report in writing, with copies to the Drug Enforcement Administration and the Board within seven days of the discovery.~~
1. Immediately notify the local law enforcement agency,
 2. Provide that agency with a written report, and
 3. Send a copy to the Drug Enforcement Administration and the Board within seven days of the discovery.
- D.** For purposes of this ~~Section, section,~~ “~~Schedule II drugs or other substances~~” means the controlled substances are identified, defined, or listed in A.R.S. Title 36, Chapter 27, A.R.S. § 36-2513 and the following hallucinogenic substances:
1. Dronabinol (synthetic) in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product.
 2. Nabilone.

R4-16-205. Inspections; Denial and Revocation

- A.** A physician shall cooperate with and allow access to the physician’s office and records for periodic inspection of dispensing practices by the Board or its authorized representative. ~~representatives to the physician’s office and records during periodic inspections of dispensing practices by the Board.~~ Failure to cooperate or allow access shall be grounds for revocation of a physician’s registration to dispense a controlled substance, prescription-only drug, or prescription-only device or denial of renewal of the physician’s dispensing registration.
- B.** Failure to comply with A.R.S. § 32-1491 or this ~~Article~~ article shall ~~constitute~~ constitutes grounds for denial or revocation of dispensing registration.
- C.** The Board shall revoke a ~~A~~ physician’s registration to dispense a controlled substance, prescription-only drug, or prescription-only device ~~drugs and devices shall be revoked by the Board~~ upon occurrence of the following:

Notices of Final Rulemaking

1. ~~Suspending, revoking, surrendering, or canceling~~ ~~Suspension, revocation or cancellation~~ of the physician's license;
 2. ~~Placing~~ ~~Placement~~ of the physician's license on inactive status;
 3. ~~Failing~~ ~~Failure~~ to timely renew the physician's license; or
 4. ~~Restricting~~ ~~Restriction~~ of the physician's ability to prescribe or administer medication, including loss or expiration of ~~the~~ a physician's Drug Enforcement Administration Certificate of Registration.
- D. ~~If the Board denies a physician's dispensing registration, the physician may appeal the decision by filing a request, in writing, with the Board, no later than 30 days after receipt of the notice denying the registration. A physician denied registration may request a hearing to appeal the decision by filing the request, in writing, with the Board, not later than 10 days after receipt of the notice denying the registration.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 13. DEPARTMENT OF HEALTH SERVICES
HEALTH PROGRAMS SERVICES

PREAMBLE

1. **Sections Affected** **Rulemaking Action**
R9-13-1105 New Section
2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statutes: A.R.S. §§ 36-136(F), 36-2202(A), and 36-2209(A)
Implementing statute: A.R.S. §§ 41-1072 through 41-1079 and 36-2212
3. **The effective date of the rules:**
May 9, 2002
4. **A list of all previous notices appearing in the Register addressing the final rule:**
Notice of Rulemaking Docket Opening: 8 A.A.R. 267, January 11, 2002
Notice of Proposed Rulemaking: 8 A.A.R. 392, February 1, 2002
Notice of Public Information: 8 A.A.R. 857, March 1, 2002
5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Judi Crume, Bureau Chief
Address: Arizona Department of Health Services, Bureau of Emergency Medical Services
1651 E. Morten, Suite 120
Phoenix, AZ 85020
Telephone: (602) 861-0708
Fax: (602) 861-9812
E-mail: jcrume@hs.state.az.us
or
Name: Kathleen Phillips, Rules Administrator
Address: Arizona Department of Health Services
1740 W. Adams, Suite 102
Phoenix, AZ 85007
Telephone: (602) 542-1264
Fax: (602) 364-1150
E-mail: kphilli@hs.state.az.us

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

The proposed rulemaking adds A.A.C. Section R9-13-1105 to cross-reference the applicable time-frames for the Arizona Department of Health Services (the Department) to decide applications for air ambulance registration and registration renewal, which are specified in 9 A.A.C. 25, Article 12.

The rulemaking is necessary to establish time-frames for the Department's licensing decisions under 9 A.A.C. 13, Articles 10 and 11, to comply with the requirements in A.R.S. §§ 41-1072 through 41-1079.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

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:

This rulemaking ensures that the Department's decisions on applications for air ambulance registration and registration renewal are consistent with the requirements in A.R.S. §§ 41-1072 through 41-1079.

The rulemaking directly impacts 15 air ambulance services, which operate 70 registered air ambulances in Arizona, and the Department. The rulemaking also indirectly impacts hundreds of emergency medical services patients served annually by air ambulances.

The overall economic impact of the rulemaking is expected to be minimal, with the benefits of the rulemaking outweighing the costs. There will be no new or additional costs to air ambulance services as a result of this rulemaking.

Cost Bearers

The new time-frames are consistent with the Department's current practices and may have only a minimal impact on air ambulance services and the Department. Should the Department fail to comply with licensing time-frames, the Department could be required to issue refunds and pay penalties. However, since the Department intends to comply with all time-frame requirements, it does not believe that this will occur.

Beneficiaries

The time-frames will benefit air ambulance services by providing clarity in the licensing application process and assuring that the Department will process all applications in a fair, consistent, and timely manner.

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

No changes have been made in the text of the adopted rules from that in the proposed rules, except grammatical and organizational changes suggested by the staff of the Governor's Regulatory Review Council.

11. A summary of the principal comments and the agency response to them:

The Department did not schedule an oral proceeding on the proposed rulemaking and did not receive a written request for an oral proceeding. During the comment period of February 1, 2002 through the close of record on March 4, 2002, the Department did not receive any written or oral comments on the proposed rulemaking.

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:

None

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 13. DEPARTMENT OF HEALTH SERVICES
HEALTH PROGRAMS SERVICES**

ARTICLE 11. AMBULANCE REGISTRATION CERTIFICATE

Section

R9-13-1105. ~~Repealed~~ Time-frames for the Department's Air Ambulance Registration and Registration Renewal Decisions

Arizona Administrative Register
Notices of Final Rulemaking

ARTICLE 11. AMBULANCE REGISTRATION CERTIFICATE

R9-13-1105. Repealed Time-frames for the Department's Air Ambulance Registration and Registration Renewal Decisions

The Department shall approve or deny an application under this Article according to 9 A.A.C. 25, Article 12.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected

R9-22-101
R9-22-102
R9-22-201
R9-22-204
R9-22-205
R9-22-207
R9-22-208
R9-22-209
R9-22-210
R9-22-211
R9-22-212
R9-22-213
R9-22-215
R9-22-216

Rulemaking Action

Amend
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

Implementing statutes: A.R.S. §§ 36-2903(C) and (Q), 36-2903.01(L) and (O), 36-2907, 36-2908, and 36-2909

3. The effective date of the rules:

May 9, 2002

4. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 5261, November 23, 2001

Notice of Proposed Rulemaking: 8 A.A.R. 192, January 11, 2002

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

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

The Administration made changes to A.A.C. Title 9 to conform to state statute, federal law, and to provide additional clarity and conciseness to existing rule language. These changes impact two Articles:

- Article 1, Definitions (R9-22-101 and R9-22-102) to add and amend definitions, and
- Article 2, Scope of Services (R9-22-201 through R9-22-205; R9-22-207 through 216).

Arizona Administrative Register
Notices of Final Rulemaking

Following is an explanation of the changes:

9 A.A.C. 22, Article 1, Definitions

The Administration modified, added, or deleted definitions to improve the clarity and conciseness of the rule language.

9 A.A.C. 22, Article 2, Scope of Services

- R9-22-201 The Administration amended the content of this Section to improve the clarity and conciseness of the rule language.
- R9-22-204 The Administration amended the content of this Section to improve the clarity and conciseness of the rule language and conform to federal law (subsection (B)).
- R9-22-205 The Administration made minor changes to improve clarity.
- R9-22-207 The Administration clarified the language to more clearly identify covered dental services for members age 21 or over and members under age 21.
- R9-22-208 The Administration made minor changes to improve clarity and deleted subsection (4) as its contents are reflected in R9-22-201.
- R9-22-209 The Administration made minor changes to improve clarity and deleted subsection (D)(4) and (5) as these areas are covered under A.R.S. Title 32.
- R9-22-210 The Administration made minor changes to conform to federal law.
- R9-22-211 The Administration amended the content of this Section to improve the clarity and conciseness of the rule language.
- R9-22-212 The Administration made minor changes to improve clarity and deleted subsection (G). The deletion will allow the Administration to work with fee for service (FFS) providers in raising the threshold point at which prior authorization (PA) is needed for medical supplies and durable medical equipment. This makes the PA process less burdensome for the FFS providers.
- R9-22-213 The Administration added Hospice services, which have been part of the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) service package but not reflected in rule and added references to 42 CFR 441 Subpart B and A.A.C. R9-7-301 for content.
- R9-22-215 The Administration made minor changes to improve clarity.
- R9-22-216 The Administration made minor changes to improve clarity.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

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 contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define the scope of services for AHCCCS' acute care program. The Administration is amending these rules to make the rules more clear, concise, and understandable by:

- Grouping like concepts to provide clarity and conciseness to the rule language,
- Clarifying language that does not clearly present policies or procedures, and
- Updating citations to documents incorporated in the rule, as needed.

It is anticipated that the private sector, including small businesses or political subdivisions will not be impacted because the proposed rule language changes are intended to streamline and clarify the existing rules. The Administration, contractors, and providers will benefit because the changes provide greater flexibility and clarification of the rule language.

Notices of Final Rulemaking

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

The changes between proposed and final are as follows:

1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.
2.	General	The Administration made other technical and grammatical changes based on suggestions from G.R.R.C. staff.
3.	R9-22-101(B)	The second phrase was deleted from the definition of “Attending Physician” in order to clarify that the use of Attending Physician in this Article is limited to Fee-For-Service (FFS) population.
4.	R9-22-101(B)	The term “investigation services” was deleted from the definition of Experimental Services.
5.	R9-22-101 and R9-22-102	The term provider has been deleted.
6.	R9-22-201 (D) (Now (D) and (E))	Prior Period coverage (PPC) and emergency services were both covered in the same subsection but now each is placed in its own subsection.
7.	R9-22-201 (H) (Now (I))	The scope of subsection (H) is limited to FFS population only. “FFS” was added for clarity. Subsection (J) was deleted and the concept added to subsection (E). Due to the language being clarified, the organization of the language is understandable.
8.	R9-22-101(B)	The second phrase was deleted from the definition of “Attending Physician”. Attending physician in this Article by history has been and will continue to be limited to FFS population.
9.	R9-22-201	The content of subsections (A) and (B) were reworked to correct syntax and improve clarity

11. A description of the principal comments and the agency response to them:

The principal comments received by the Administration are listed below:

	<u>Subsection</u>	<u>Comments</u>	<u>Response</u>
1.	R9-22-201 (D) and (E)	The first sentence addresses the provision that no authorization is required for prior period coverage (PPC) or emergency services. The following sentence does not give due emphasis on an important provision, that is, the authorization requirement for diagnostic and treatment procedures for a condition unrelated to the emergent condition. The language currently states for diagnostic and treatment procedures for an unrelated emergent condition; Mercy Care Plan suggests changing condition to episode and separating this provision. (Mercy Care Plan)	Reached Agreement/ Reworked the language to increase clarity but kept the word “condition.” Made PPC and emergency services separate entities.
2.	R9-22-201 (E) (Now (F))	A. Language should be added to R9-22-201(E) to reflect that a provider can refer a member out of the contractor’s area for medical specialty care when the specialty care is not available within the contractor’s service area. (Mercy Care Plan)	No Change After discussion, Mercy Care agreed that their issue rests in contract, not rule, and that the language need not be changed.

Arizona Administrative Register

Notices of Final Rulemaking

3.	R9-22-201 (H) (Now I)	The language of subsection (H) of this Section should follow (E) to prevent misunderstanding regarding the Administration having the ultimate authority to decide when non-emergent services are provided outside the service area even if the PCP has referred outside the area. (Mercy Care Plan)	Changed Language to Increase Clarity The scope of subsection (H) is limited to fee for service (FFS) population only. The language was clarified to reflect this.
4.	R9-22-211(B)	Concern about the effectiveness of R9-22-211(B) regarding air transport <u>Air Evac v. APIPA (875 p.2d 193)</u> has been used by the OAH and supported in AHCCCS decisions for the proposition that it is the requesting physician who determines when air transports are medically necessary. There is no discussion of any criteria similar to that proposed in rule for reimbursement of this service. (Mercy Care Plan)	No Change The rule upon which the court case was based has since been amended. 42 CFR 440.230(d) provides that: "The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." A.R.S. §§ 36-2903B.4. and 2907 C also authorize the Administration to limit services to those which are medically necessary. AHCCCS has written in rule appropriate criteria and guidance under its authority.
5.	R9-22-101-102	AHCCCS deleted numbering system for definitions. Opposes the deletion of numbers in R9-22-102. "New definitions are not added with any frequency." The Administration should consider reinstating the numbering system in all definition sections. (Gammage and Burnham)	Disagree Definitions are in alphabetical versus numerical order. AHCCCS adds, deletes or amends the definition sections with almost every rule package. It is cumbersome for AHCCCS to have to renumber each time. It is more time efficient to have the definitions in alphabetical order and it is allowable per the Secretary of State's Office (SOS).
6.	R9-22-101(B)	The issue is with the second clause of the definition of "attending physician," which provides an alternative definition of attending physician for the fee-for-service population and the only definition for the enrolled population. In this second clause, designation as an attending physician depends on securing a referral from a PCP. This is simply not practical in the context of patients who are hospitalized on an emergent or urgent basis, where there is generally little or no PCP involvement, and plan protocol itself may require none. The regulation should therefore be amended to make the first clause applicable to both the fee-for-service population and plan population, creating alternative definitions for both groups, or the reference to PCP referrals be limited to the non-hospitalized populations. (Gammage and Burnham)	Agreed to delete the second clause The second clause is deleted. The use of the phrase "Attending physician" in this Article by history has been and will continue to be limited to FFS population. A definition of "Attending physician" was added to clarify the use of the term in this Chapter.

Arizona Administrative Register
Notices of Final Rulemaking

7.	R9-22-101 R9-22-201 (B)(5) (Now (B)(11))	<p>The proposed definition equates experimental services with investigational services. The federal Medicare and FDA laws distinguish between the two, and certain investigational services are covered.</p> <p>We believe that the definitions in these linked programs overseen by the same federal agency (CMS) should be the same, and that adopting a two tiered definition will give AHCCCS more flexibility in the long run.</p> <p>The regulation as drafted allows the administration to exclude services that are experimental or performed “primarily for the purposes of research.” The phrase “primarily for the purposes of research” should be defined in regulation. (Gammage and Burnham)</p>	<p>Disagree Medicare and Medicaid are not linked together; they are two separate programs. Medicaid does not differentiate between investigational and experimental.</p> <p>In order to make the definition clear and concise we have deleted “<u>means investigational services.</u>”</p> <p>Citation to the judicial decision regarding experimental services that we relied on in drafting the rule language is <u>Miller by Miller v. Whitburn</u>, 10 F.3rd 1315, 1320 (7th Cir., 1993). The Administration has adopted the definition of the term “experimental” from this court case and incorporated it in its regulations.</p> <p>The phrase “primarily for the purposes of research” is used in its commonly understood sense.</p>
8.	R9-22-102	<p>The definition of provider, tied to contracting status, is inconsistent with the definition of a noncontracting provider in A.R.S. § 36-2901, or the Administration’s own use of the term throughout these regulations.</p> <p>The definition should be deleted. If AHCCCS needs to limit references to providers to those who are contracted, subcontracted, or non-contracted, it should do so explicitly by use of those terms. (Gammage and Burnham)</p>	<p>Agree The definition of provider has been deleted.</p>
9.	R9-22-201	<p>Note that syntax and grammar of R9-22-201(A) and (B) are awkward. In a similar manner, the sentences created by R9-22-201(B)(1) and each of its subsections are grammatically incomplete and unclear. (Gammage and Burnham)</p>	<p>Agree Subsections (A) and (B) have been revised to improve clarity.</p>
10.	R9-22-201 (B)(1) (now (B)(4))	<p>PCP’s are frequently uninvolved with the hospitalized population. Requiring that they must be involved for services to be covered is inappropriate and unworkable.</p> <p>The word “except” should be inserted before the phrase “as authorized by the Administration or contractor.” (Gammage and Burnham)</p>	<p>Agree/Changed</p>
11.	R9-22-201 (B)(1)(a) (now (B)(1))	<p>We object to the link between covered services, which are defined by state and federal law, and “cost effectiveness” or the existence of state and federal reimbursement. Covered services are those specified by statute as covered, and the agency cannot limit this coverage on its own initiative. (Gammage and Burnham)</p>	<p>No Change AHCCCS explained that A.R.S. § 36-2903 (B)(4) gives the Administration the authority to include cost effective and review of utilization of services. Covered services must also be medically necessary.</p> <p>This does not limit the service or coverage but assists in determining the most efficient and effective approach to the member’s treatment also taking into account the efficacy of the approach.</p>

Arizona Administrative Register

Notices of Final Rulemaking

12.	R9-22-201 (B)(1)(b) (Now (B)(2))	The Administration has consistently stated on public forums, meetings, and administrative hearings that the only definition of coverage for the SES and FES programs are those specified in the federal definition itself-that the patient experience sudden onset of symptoms of sufficient severity that the absence of immediate medical attention is reasonably likely to cause serious jeopardy to the patient's health, serious impairment or serious dysfunction. Therefore, there appears to be no legal basis or authority for the existence of this regulation or the existing R9-22-217. Both should be deleted. (Gammage and Burnham)	No Change R9-22-217 was amended and filed as exempt with the Secretary of State as of November 1, 2001. Gammage and Burnham had reviewed the version of rule prior to this date. R9-22-217 was changed to conform to the federal definition with the limited exception that AHCCCS also include the requirement that all conditions must coexist simultaneously for coverage. This requirement is based on direction from Center for Medicaid and Medicare Services (CMS) and Second Circuit Court of Appeals decision in <u>The Greenery Rehabilitation Group, Inc. v. Hammon</u> , 150 F.3d 226 (2nd Cir. 1998). CMS clarified in its correspondence with the AHCCCS Director on August 8, 2001 that federal funding is not available for emergency services that do not comply with section 1903(v) as interpreted by the Court in Greenery.
13.	R9-22-201 (B)(1)(c) (Now (B)(2))	The comma after "practitioner" should be deleted. (Gammage and Burnham)	Agree/Changed Language updated.
14.	R9-22-201 (B)(1)(d)	There should be no requirement that the PCP issue a referral for specialty care if a patient is hospitalized and under the care of an attending Physician. (Gammage and Burnham)	Clarified Language The language is deleted.
15.	R9-22-201 (B)(2) (Now (B)(8))	The Medical Officer has authority to review care to determine if the standard of care was met. However, this role is far different from granting the AHCCCS Chief Medical Officer sole and complete discretion to determine the standard of care itself. The phrase "as determined by the AHCCCS Chief Medical Officer" should be deleted. (Gammage and Burnham)	Clarified Language Language is changed to read "A member may receive treatment that is considered the standard of care or that is approved by the AHCCCS Chief Medical Officer after appropriate consultative input."
16.	R9-22-201 (B)(3) (Now (B)(9))	To the extent that this subsection could be construed as allowing the Administration and plans to contractually limit services to enrollees, the regulation is without legal authority. The contracts between the plans and the Administration govern plan operation, not coverage. This phrase should be deleted. (Gammage and Burnham)	Change The language has been changed to reflect services as delineated in the Administration's 1115 Waiver with CMS. <u>"A member shall receive services according to the Section 1115 Waiver as defined in A.R.S. 36-2901."</u>
17.	R9-22-201 (F), (H), and (J)	Subsection (H) appears redundant to subsection (F). Subsection (J) also concerns out of area services. It would increase clarity to combine all sections concerning out of area coverage in a single Section. (Gammage and Burnham)	Clarified Language The scope of subsection (H) is limited to the FFS population only. (F) is limited to the population under Contracted Health Plans. Due to the language being clarified, the organization of the language is understandable. Deleted (J). Added wording from (J) to (F)

Arizona Administrative Register

Notices of Final Rulemaking

18.	R9-22-201 (L)	This regulation allows AHCCCS to alter the benefit package to virtually all eligibility groups without promulgation of any regulations or any public process. A.R.S. § 36-2907 does not give the Director such unfettered discretion. The extent of coverage is clearly a “rule” under the Arizona Administrative Procedure Act and any changes to coverage must therefore be promulgated. (Gammage and Burnham)	Agree Deleted all of (L) The rule language was redundant of that which is stated in statute.
19.	R9-22-204(B)	This regulation, requiring hospitals to notify AHCCCS by the fourth day of hospitalization for non-ICU care and the second day of hospitalization for ICU care is a hold-over from the earliest days of the program, and has outlived any usefulness it might have had. The shorter notification for ICU care should be eliminated. (Gammage and Burnham)	Disagree The notice is the “trigger” to initiate concurrent review for FFS members. This process is to allow concurrent review of whether or not the level of care is appropriate and/or a change is needed. Members in ICU are at a higher level of care and incur higher costs. It is therefore prudent to have a concurrent review to determine expediently whether the Administration agrees with the hospital regarding the member’s stay in the ICU. If notification were not provided within this time-frame, the determination would default to a retrospective review. This has the potential to result in more contentious debate regarding the appropriateness of the member’s stay in ICU and increased hearings and legal actions.
20.	R9-22-205(B)(5)	The word “is” in the first line is shown underlined (new language) rather than stricken, and is therefore the only word in this subsection. (Gammage and Burnham)	Agree/ Changed
21.	R9-22-217(B) Should be 215, 217 does not exist.	The reference to “(12)” in the second line should read “(13)”. (Gammage and Burnham)	Reached Agreement/No Change AHCCCS explained that this is correct.

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:

42 CFR 418.202, December 20, 1994, R9-22-213

42 CFR 441, Subpart B, January 29, 1985, R9-22-213

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 (AHCCCS)
ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section

- R9-22-101. Location of Definitions
- R9-22-102. Scope of Services Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section

- R9-22-201. General Requirements
- R9-22-204. Inpatient General Hospital Services
- R9-22-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Attending Physician, Practitioner, and Primary Care Provider Services
- R9-22-207. Dental Services
- R9-22-208. Laboratory, Radiology and Medical Imaging Services
- R9-22-209. Pharmaceutical Services
- R9-22-210. Emergency Medical and Behavioral Health Services
- R9-22-211. Transportation Services
- R9-22-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices
- R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
- R9-22-215. Other Medical Professional Services
- R9-22-216. NF, Alternative HCBS Setting, or HCBS

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”	R9-22-107
“Act”	R9-22-114
“Active case”	R9-22-109
“ADHS”	R9-22-112
“Administration”	A.R.S. § 36-2901
“Administrative law judge”	R9-22-108
“Administrative review”	R9-22-108
“Advanced Life Support” or “ALS”	<u>R9-25-101</u>
“Adverse action”	R9-22-114
“Affiliated corporate organization”	R9-22-106
“Aged”	42 U.S.C. 1382c(a)(1)(A) and R9-22-115
“Aggregate”	R9-22-107
“AHCCCS”	R9-22-101
“AHCCCS inpatient hospital day or days of care”	R9-22-107
“AHCCCS registered provider”	<u>R9-22-101</u>
“Ambulance”	R9-22-102 <u>A.R.S. Title 36, Chapter 21.1</u>
“Ancillary department”	R9-22-107
“Annual assessment period”	R9-22-109
“Annual assessment period report”	R9-22-109
“Annual enrollment choice”	R9-22-117
“Appellant”	R9-22-114
“Applicant”	R9-22-101
“Application”	R9-22-101
“Assignment”	R9-22-101
“Attending physician”	<u>R9-22-101</u>
“Authorized representative”	R9-22-114
“Auto-assignment algorithm”	R9-22-117
“Baby Arizona”	R9-22-114
“Basic Life Support” or “BLS”	<u>R9-25-101</u>

Arizona Administrative Register

Notices of Final Rulemaking

“Behavior management services”	R9-22-112
“Behavioral health evaluation”	R9-22-112
“Behavioral health medical practitioner”	R9-22-112
“Behavioral health professional”	R9-20-101
“Behavioral health service”	R9-22-112
“Behavioral health technician”	R9-20-101
“Behavior management services”	R9-22-112
“BHS”	R9-22-114
“Billed charges”	R9-22-107
“Blind”	R9-22-115
“Board-eligible for psychiatry”	R9-22-112
“Burial plot”	R9-22-114
“Capital costs”	R9-22-107
“Capped fee-for-service”	R9-22-101
“Caretaker relative”	R9-22-114
“Case”	R9-22-109
“Case record”	R9-22-101 and R9-22-109
“Case review”	R9-22-109
“Cash assistance”	R9-22-114
“Categorically-eligible”	R9-22-101
“Certified psychiatric nurse practitioner”	R9-22-112
“Clean claim”	A.R.S. § 36-2904
“Clinical supervision”	R9-22-112
“CMDP”	R9-22-117
“CMS”	R9-22-101
“Complainant”	R9-22-108
“Continuous stay”	R9-22-101
“Contract”	R9-22-101
“Contractor”	A.R.S. § 36-2901
“Copayment”	R9-22-107
“Corrective action plan”	R9-22-109
“Cost-to-charge ratio”	R9-22-107
“Covered charges”	R9-22-107
“Covered services”	R9-22-102
“CPT”	R9-22-107
“CRS”	R9-22-114
“Cryotherapy”	R9-22-120
“Date of notice”	R9-22-108
“Day”	R9-22-101
“DCSE”	R9-22-114
“De novo hearing”	42 CFR 431.201
“Dentures”	R9-22-102
“Department”	A.R.S. § 36-2901
“Dependent child”	R9-22-114 <u>A.R.S. § 46-101</u>
“DES”	R9-22-101
“Diagnostic services”	R9-22-102
“Director”	R9-22-101
“Disabled”	R9-22-115
“Discussions”	R9-22-106
“Disenrollment”	R9-22-117
“District”	R9-22-109
“DME”	R9-22-102
“DRI inflation factor”	R9-22-107
“E.P.S.D.T. services”	R9-22-102 <u>42 CFR 441 Subpart B</u>
“Eligible person”	A.R.S. § 36-2901
“Emergency medical condition”	Section 1903(v) of the Social Security Act <u>42 U.S.C. 1396b(v)(3)</u>
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107

Arizona Administrative Register

Notices of Final Rulemaking

“Enrollment”	R9-22-117
“Enumeration”	R9-22-101
“Equity”	R9-22-101
<u>“Experimental services”</u>	<u>R9-22-101</u>
“Error”	R9-22-109
“FAA”	R9-22-114
“Facility”	R9-22-101
“Factor”	R9-22-101
“FBR”	R9-22-101
<u>“Fee-For-Service” or “FFS”</u>	<u>R9-28-101</u>
“FESP”	R9-22-101
“Finding”	R9-22-109
“First-party liability”	R9-22-110
“Foster care maintenance payment”	42 U.S.C. 675(4)(A)
“Federal poverty level” (“FPL”)	A.R.S. § 1-215
“FQHC”	R9-22-101
“Grievance”	R9-22-108
“GSA”	R9-22-101
“Health care practitioner”	R9-22-112
“Hearing”	R9-22-108
“Hearing aid”	R9-22-102
“Home health services”	R9-22-102
“Homebound”	R9-22-114
“Hospital”	R9-22-101
<u>“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”</u>	<u>42 CFR 483 Subpart I</u>
“ICU”	R9-22-107
“IHS”	R9-22-117
“IMD”	<u>42 CFR 435.1009 and</u> R9-22-112
“Income”	R9-22-114
“Inmate of a public institution”	42 CFR 435.1009
“Interested party”	R9-22-106
“LEEP”	R9-22-120
“License” or “licensure”	R9-22-101
“Mailing date”	R9-22-114
“Management evaluation review”	R9-22-109
“Medical education costs”	R9-22-107
“Medical expense deduction”	R9-22-114
“Medical record”	R9-22-101
“Medical review”	R9-22-107
“Medical services”	A.R.S. § 36-401
“Medical supplies”	R9-22-102
“Medical support”	R9-22-114
“Medically necessary”	R9-22-101
“Medicare claim”	R9-22-107
“Medicare HMO”	R9-22-101
“Member”	A.R.S. § 36-2901
“Mental disorder”	A.R.S. § 36-501
“New hospital”	R9-22-107
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2901
“Nonparent caretaker relative”	R9-22-114
“Notice of Findings”	R9-22-109
“OAH”	R9-22-108
“Occupational therapy”	R9-22-102
“Offeror”	R9-22-106
“Ownership interest”	42 CFR 455.101
“Operating costs”	R9-22-107

Arizona Administrative Register

Notices of Final Rulemaking

“Outlier”	R9-22-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial Care”	R9-22-112
“Party”	R9-22-108
“Peer group”	R9-22-107
“Performance measures”	R9-22-109
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Prior period coverage” or “PPC”	R9-22-107
“Post-stabilization care services”	42 CFR 422.113
“Practitioner”	R9-22-102
“Pre-enrollment process”	R9-22-114
“Preponderance of evidence”	R9-22-109
“Prescription”	R9-22-102
“Primary care provider”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Proposal”	R9-22-106
“Prospective rates”	R9-22-107
“Prospective rate year”	R9-22-107
“Psychiatrist”	R9-22-112
“Psychologist”	R9-22-112
“Psychosocial rehabilitation services”	R9-22-112
“Qualified alien”	A.R.S. § 36-2903.03
“Quality management”	R9-22-105
“Radiology services”	R9-22-102
“Random sample”	R9-22-109
“RBHA”	R9-22-112
“Rebasing”	R9-22-107
“Referral”	R9-22-101
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“Resources”	R9-22-114
“Respiratory therapy”	R9-22-102
“Respondent”	R9-22-108
“Responsible offeror”	R9-22-106
“Responsive offeror”	R9-22-106
“Review”	R9-22-114
“Review period”	R9-22-109
“RFP”	R9-22-106
“Scope of services”	R9-22-102
“SDAD”	R9-22-107
“Section 1115 Waiver”	A.R.S. § 36-2901
“Service location”	R9-22-101
“Service site”	R9-22-101
“SESP”	R9-22-101
“S.O.B.R.A.”	R9-22-101
“Specialist”	R9-22-102
“Specified relative”	R9-22-114
“Speech therapy”	R9-22-102
“Spendthrift restriction”	R9-22-114
“Spouse”	R9-22-101
“SSA”	42 CFR 1000.10
“SSI”	42 CFR 435.4
“SSN”	R9-22-101
“Stabilize”	42 U.S.C. 1395dd

“Standard of care”	R9-22-101
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
“Summary report”	R9-22-109
“SVES”	R9-22-114
“Third-party”	R9-22-110
“Third-party liability”	R9-22-110
“Tier”	R9-22-107
“Tiered per diem”	R9-22-107
“Title IV-D”	R9-22-114
“Title IV-E”	R9-22-114
“Tolerance level”	R9-22-109
“Utilization management”	R9-22-105
“WWHP”	R9-22-120

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:

“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:

Has a provider agreement under A.R.S. § 36-2904,

Meets state and federal requirements for providing covered services, and

Is appropriately licensed or certified to provide covered services.

“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.

“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 AHCCCS-covered service and equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

~~“Case record” means an applicant’s or member’s file and all documents in the file that are used to establish eligibility.~~

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

“CMS” means the Centers for Medicare and Medicaid Services.

“Continuous stay” means the 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.

“Day” means a calendar day unless otherwise specified.

“DES” means the Department of Economic Security.

“Director” means the Director of the Administration or the Director’s designee.

“Eligible person” means a person as defined in A.R.S. § 36-2901.

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

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

“Experimental services” are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States;

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States;

Lacks authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown in the professional medical community.

Arizona Administrative Register
Notices of Final Rulemaking

“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.

“Factor” means an organization, a collection agency, a service bureau, or a person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, the collection agency, the service bureau, or the person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term “factor” does not include a business representative, such as a bailing agent or an accounting firm described in this Chapter, or a health care institution.

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

“FESP” means a federal emergency services program covered under R9-22-217, to treat an emergency medical 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 ~~of record~~ provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor of record.

“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.

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

“Medical record” means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

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

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

“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.

“Service location” means a location at which a member obtains a covered health care 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 ~~of record~~ as the location at which a member is to receive covered health care services.

“SESP” means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.

“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).

“Spouse” means a person who has entered into a contract of marriage, recognized as valid by Arizona.

“SSN” means social security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, or injury, 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 who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor’s obligation to the Administration under the terms of a contract.

Arizona Administrative Register
Notices of Final Rulemaking

R9-22-102. 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:

~~“Ambulance” means a medical transport vehicle that is registered by and part of an ambulance service licensed by the Arizona Department of Health Services according to A.R.S. Title 36, Chapter 21.1, and 19 A.A.C. 13; and includes ground, air, and water ambulances that are staffed and equipped as a basic life support (BLS) vehicle or an advanced life support (ALS) vehicle. Ambulances may be used to provide:~~

~~Emergency transportation for eligible persons or members a member requiring emergency medical services; or
Medically necessary transportation from one medical facility to another; and or~~

~~Any necessary emergency medical services that a certified emergency medical technician (EMT), an Intermediate EMT or paramedic, a registered nurse or a physician assistant, provides before, during, or after transportation.~~

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

~~“Dentures” means a partial or complete set of artificial teeth and services that are determined to be medically necessary; and the primary treatment of choice, or an essential part of an overall treatment plan, designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.~~

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

~~“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.~~

~~“Emergency medical services” means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:~~

- ~~a. Placing the patient’s health in serious jeopardy;~~
- ~~b. Serious impairment to bodily functions; or~~
- ~~e. Serious dysfunction of any bodily organ or part.~~

~~“E.P.S.D.T. services” means early and periodic screening, diagnosis, and treatment services for eligible persons or members less than 21 years of age. For the purpose of these rules-~~

~~“Early” means, in the case of an eligible person less than 21 years of age, as early as possible in the person’s life or, in other cases, as soon as the person becomes eligible;~~

~~“Periodic” means at appropriate intervals established by the Administration for screening to ensure that a condition, illness, or injury is not incipient or present;~~

~~“Screening” means the use of quick, simple procedures carried out among large groups of people to distinguish apparently well persons from those who may have a condition, illness, or injury and the identification of those in need of more definitive study. For the purposes of AHCCCS, screening and diagnosis are not synonymous;~~

~~“Diagnosis” means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, X rays; and~~

~~“Treatment” means any type of health care or service recognized under the state Plan submitted according to Title XIX of the Social Security Act to prevent or ameliorate a condition, illness, or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.~~

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

~~“Home health services” means the services that are provided by a home health agency that coordinates in-home intermittent services for curative, rehabilitative care. This includes home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.~~

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

~~“Occupational therapy” means the 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, and are dispensed by a licensed pharmacist through a registered pharmacy 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.~~

~~“Physician” means a person licensed as an allopathic or osteopathic physician according to under A.R.S. Title 32, Chapter 13 or Chapter 17.~~

Arizona Administrative Register
Notices of Final Rulemaking

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

“Prescription” means an order to provide covered services, which is signed or transmitted by a provider authorized to prescribe or order services.

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

“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.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on ~~their~~ the medical necessity of the services.

“Private duty nursing services” means nursing services provided to a member ~~or eligible person~~ who requires more individual and continuous care than is available from a visiting nurse, or routinely provided by the nursing staff of a nursing facility or ICF-MR, and that are provided by a registered nurse or licensed practical nurse.

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

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

“Respiratory therapy” means treatment services to restore, maintain, or improve respiratory functions and is 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 ~~these rules.~~ this Chapter.

“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.

“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 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.

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. General Requirements

- ~~A. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:~~
- ~~1. Covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.
 - ~~a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished, by the primary care provider delegating the provision of primary care for a member to a practitioner.~~
 - ~~b. Behavioral health screening and evaluation services may be provided, without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from and in consultation with the PCP, or upon authorization by the contractor or its designee.~~
 - ~~e. The contractor may waive the referral requirements.~~~~
 - ~~2. Covered services provided to an eligible person through the AHCCCS Administration shall be medically necessary and provided by, or under the direction of, an attending physician, practitioner, or dentist;~~
 - ~~3. Services shall be rendered in accordance with state and federal laws and regulations, the Arizona Administrative Code and AHCCCS contractual requirements;~~
 - ~~4. Experimental services as determined by the director, or services provided primarily for the purpose of research, shall not be covered;~~
 - ~~5. AHCCCS services shall be limited to those services that are not covered for a member or eligible person who is a Medicare beneficiary;~~
 - ~~6. Services or items, if furnished gratuitously, are not covered and payment shall be denied;~~
 - ~~7. Personal care items are not covered and payment shall be denied;~~
 - ~~8. AHCCCS covered services shall not be covered 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~~~~

Arizona Administrative Register
Notices of Final Rulemaking

- e. ~~A person age 21 through 64 who is in an institution for the treatment of mental diseases, unless provided under Article 12.~~
- B.** ~~Services shall be provided by AHCCCS registered personnel or facilities that meet state and federal requirements, and are appropriately licensed or certified to provide the services.~~
- C.** ~~Payment for services or items requiring prior authorization may be denied if prior authorization by the Administration or contractor is not obtained. Services provided during the prior period coverage do not require authorization. Emergency services under A.R.S. § 36-2908 do not require prior authorization.~~
 - 1. ~~For an eligible person, the AHCCCS Administration shall prior authorize services based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the eligible person's attending physician or practitioner.~~
 - 2. ~~Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.~~
 - 3. ~~In addition to the requirements of Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.~~
- D.** ~~Covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:~~
 - 1. ~~A primary care provider refers a member out of the contractor's area for medical specialty care;~~
 - 2. ~~A covered service that is medically necessary for a member is not available within the contractor's service area;~~
 - 3. ~~A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;~~
 - 4. ~~A member is placed in a nursing facility located out of the contractor's service area;~~
 - 5. ~~Services provided are during the prior period coverage time frame authorized under Article 3; and~~
 - 6. ~~The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.~~
- E.** ~~When a member is traveling or temporarily residing out of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.~~
- F.** ~~A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.~~
- G.** ~~If a member or eligible person requests the provision of a service that is not covered by AHCCCS or not authorized by the contractor, the service may be rendered to the member or eligible person by an AHCCCS registered service provider under the following conditions:~~
 - 1. ~~A document that lists the requested services and the estimated cost of each is prepared by the contractor and provided to the member or eligible person; and~~
 - 2. ~~The signature of the member or eligible person is obtained in advance of service provision indicating that the services have been explained to the member or eligible person, and that the member or eligible person accepts responsibility for payment.~~
- H.** ~~The Director shall determine the circumstances under which an eligible person may receive services, other than emergency services, from service providers outside the eligible person's county of residence, or outside the state. Criteria considered by the Director in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.~~
- I.** ~~If a member is referred out of the contractor's service area to receive an authorized medically necessary service the contractor shall also provide all other medically necessary covered services for the member during that time.~~
- J.** ~~The restrictions, limitations, and exclusions in this Article shall not apply to the following groups:~~
 - 1. ~~Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and wishing to negotiate for extended benefits; and~~
 - 2. ~~Contractors electing to provide noncovered services.~~
 - a. ~~The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.~~
 - b. ~~Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XIX services.~~
- K.** ~~In accordance with A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors and counties, modify the list of services for all members except those members categorically eligible according to Title XIX of the Social Security Act, as amended.~~
- A.** For the purposes of this Article.
 - 1. Authorization means written or verbal authorization by:
 - a. The Administration for services rendered to a fee-for-service member, and 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.

Arizona Administrative Register
Notices of Final Rulemaking

- B.** In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally and state reimbursable services are covered services;
 2. Covered services for the state and federal emergency services programs (FESP and SESP) are under R9-22-217;
 3. The Administration or a contractor may waive the covered services referral requirements required by 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 shall 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 and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
 7. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative input from providers who are considered experts in the field by the professional medical community;
 8. A member shall receive services according to the Section 1115 Waiver as defined in A.R.S. § 36-2901;
 9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice;
 10. 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 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; and
 11. 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 provided under Article 12 of this Chapter.
- C.** The Administration or 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. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.
- 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. Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the Administration or contractor.
- F.** A member shall receive covered services outside the contractor's service area only if one of the following apply:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If a member is referred out of the contractor's service area 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 service area 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 contractor's service area; or
 4. Services are provided during the prior period coverage time-frame.
- G.** If a member is traveling or temporarily residing out of the member's contractor service area, 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 Article, 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.** If a member requests the provision of a service that is not covered or not authorized by a contractor or the Administration, an AHCCCS registered provider may render the service and request reimbursement from the member if:
1. The provider prepares and provides the member with a document that lists the requested services and the estimated cost of each service, and
 2. The member signs the document prior to the provision of services indicating that the member understands and accepts the responsibility for payment.
- K.** The restrictions, limitations, and exclusions in this Article do not apply to the following groups:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and benefits not covered by AHCCCS; and

Arizona Administrative Register
Notices of Final Rulemaking

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.

R9-22-204. Inpatient General Hospital Services

~~A. Inpatient services provided in a general hospital shall be provided by contractors, fee-for-service providers, or noncontracting providers and shall include:~~

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), ~~36-2901.01, and 36-2901.04 provided under 9 A.A.C. 22, 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 ~~prescribed~~ 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 ~~general inpatient~~ inpatient general hospital services that are provided by ~~fee-for-service FFS~~ providers, and for which the Administration is financially responsible:

- ~~1. The cost of inpatient hospital accommodation for a member shall be incorporated into the rate paid for the level of care as specified in subsection (A)(1).~~
- ~~2. Prior authorization shall be obtained from the Administration for the following inpatient hospital services provided to a member:~~
 - ~~a. Nonemergency and elective admission, including psychiatric hospitalization;~~
 - ~~b. Elective surgery, with the exception of voluntary sterilization procedures, shall be authorized before the surgery;~~
 - ~~c. An emergency hospitalization that exceeds three days or an intensive care unit admission that exceeds one day;~~
 - ~~d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through AHCCCS Administration concurrent team review; and~~
 - ~~e. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury before service delivery.~~
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
 - c. Services or items provided to cosmetically 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.

R9-22-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Attending Physician, Practitioner, and Primary Care Provider Services

~~A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. Title 32. A member may receive these services through an~~

Arizona Administrative Register
Notices of Final Rulemaking

~~attending physician or practitioner. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:~~

- A.** A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment;
 2. Evaluation and diagnostic workup;
 3. Medically necessary treatment;
 4. Prescriptions for medication and medically necessary supplies and equipment;
 5. Referral to a specialist or other health care professional if medically necessary;
 6. Patient education;
 7. Home visits if medically necessary;
 8. Covered immunizations; and
 9. Covered preventive health services.
- B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner ~~shall be~~ are limited to the service or condition for which the referral is made, or for which authorization is given ~~by the Administration or a contractor, unless referral is waived by the Administration;~~
 2. ~~If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), the physical examination shall be covered by the member's contractor, or the Administration, except if an additional or alternative objective to satisfy the requirement of an outside public or private agency. Alternative objectives may include physical examination and resulting documentation for:~~
 2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
 - a. Qualification for insurance;
 - b. Pre-employment physical evaluation;
 - c. Qualification for sports or physical exercise activities;
 - d. Pilot's examination ~~(FAA)~~ for the Federal Aviation Administration;
 - e. Disability certification ~~for establishing~~ to establish any kind of periodic payments;
 - f. Evaluation ~~for establishing 3rd~~ to establish third-party liabilities; or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
 3. Orthognathic surgery ~~shall be~~ is covered only for ~~members who are~~ a member who is less than 21 years of age;
 4. The following services ~~shall be~~ are excluded from AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and ~~sex change operations~~ gender reassignment surgeries;
 - b. ~~Abortion~~ Pregnancy termination counseling services;
 - e. ~~Abortions, unless authorized under federal or state law~~
 - c. For federally funded programs, pregnancy terminations, unless required by federal law.
 - d. For the state emergency services programs (SESP), pregnancy terminations that are not permitted by state law.
 - ~~d-e.~~ Services or items furnished solely for cosmetic purposes; and
 - e-f. Hysterectomies unless determined medically necessary.
 5. ~~Prior authorization from the Administration shall be~~ is required for fee-for-service providers to render the following services to members:
 - a. Elective or scheduled surgeries with the exception of voluntary sterilization procedures;
 - b. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-22-207. Dental Services

- A.** ~~Emergency dental care, which encompasses the following services, shall be covered: The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.~~
1. ~~Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;~~
 2. ~~Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;~~
 3. ~~Initial treatment for acute infection;~~
 4. ~~Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;~~

Arizona Administrative Register
Notices of Final Rulemaking

5. Preoperative procedures; and
 6. Anesthesia appropriate for optimal patient management
- B.** The following limitations shall apply to emergency dental services provided by the Administration's fee-for-service providers:
1. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are limited to treatment for acute infection or to eliminate pain;
 2. Routine restorative procedures and routine root canal therapy are not emergency services;
 3. Radiographs are limited to symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;
 4. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and
 5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
- B.** The Administration or a contractor shall cover the following emergency dental care services:
1. Oral diagnostic examination including laboratory and radiographs if necessary to determine an emergency medical condition;
 2. Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition;
 3. Initial treatment for acute infection;
 4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
 5. Preoperative procedures; and
 6. Anesthesia appropriate for optimal patient management.
- C.** Covered denture services ~~include~~ are medically necessary dental services and procedures associated with, and including, the provision of dentures.
- D.** The following limitations ~~shall~~ apply to dentures; ~~provided by the Administration's fee-for-service providers:~~
1. Provision of dentures for cosmetic purposes is not a covered service;
 2. Extractions of asymptomatic teeth are not covered unless their removal ~~constitutes~~ is the most cost-effective dental procedure for the provision of dentures; and
 3. Radiographs are ~~limited to use~~ covered only if used as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures; ~~and~~
 4. ~~Prior authorization of dental services for an eligible person is required from the Administration for the following:~~
 - a. ~~Provision of medically necessary dentures;~~
 - b. ~~Replacement, repair, or adjustment to dentures; and~~
 - e. ~~Provision of obturators or other prosthetic appliances for restoration or rehabilitation.~~
- E.** The following limitations apply to emergency dental services provided by the Administration's fee-for-service providers for a member age 21 or older:
1. Treatment for the prevention of pulpal death and imminent tooth loss is covered only for non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are covered only to treat active infection or to eliminate pain;
 2. Routine restorative procedures and routine root canal therapy are not emergency services and are not covered;
 3. Radiographs are covered only for symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;
 4. Maxillofacial dental services provided by a dentist are not covered unless prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and
 5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
- F.** Prior authorization of dental services for a FFS member is required from the Administration for the following:
1. Provision of medically necessary dentures;
 2. Replacement, repair, or adjustment to dentures; and
 3. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.

R9-22-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services ~~shall be~~ are covered services if:

1. ~~Prescribed for by the members member's by a attending physician, practitioner, primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the Administration;~~
2. ~~Provided for an eligible person by a fee-for-service provider and the services are prescribed by the attending physician, practitioner, or dentist of the eligible person;~~

Arizona Administrative Register
Notices of Final Rulemaking

2. Provided by licensed health care providers in a:
 - a. Hospital.
 - b. Clinic.
 - c. Physician's office, or
 - d. Other health care facility.
3. ~~Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and~~
4. ~~Provided by a 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 the provider's license or certification.~~

R9-22-209. Pharmaceutical Services

- ~~A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.~~
- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- ~~B. The Administration or its a contractor shall ~~make~~ require a provider to make pharmaceutical services:~~
- ~~1. available Available during customary business hours, and shall be~~
 - ~~2. located Located within reasonable travel distance of a member's residence.~~
- ~~C. Pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider unless referral is waived by the Administration or upon authorization by the contractor or its designee. Pharmaceutical services provided for an eligible person shall be covered if prescribed by the attending physician, practitioner, or dentist.~~
- C. Pharmaceutical services are covered if:
1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
 2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
 3. The contractor or its designee authorizes the service.
- ~~D. The following limitations shall apply to pharmaceutical services:~~
- ~~1. A medication personally dispensed by a physician, or 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 when if accessible pharmacies are closed.~~
 - ~~2. A prescription or refill in excess of a 30 day supply or a 100 unit dose is not covered unless:~~
 - ~~a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100 day supply or 100 unit dose, 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 100 days or 100 unit dose, whichever is greater.~~
 - ~~c. The medication is prescribed for birth control and the prescription is limited to no more than a 100-day supply.~~
 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 (D)(3).
 3. A prescription or refill in excess of a 30-day supply is covered if:
 - a. The medication is prescribed for 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 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.
 - ~~3. An over the counter medication may be covered as an alternative to prescription medication only if it is available and less costly than a prescription medication~~
 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 less costly than the covered prescription medication.
 - ~~4. A prescription is not covered if filled or refilled in excess of the number specified, or if the initial prescription or refill is dispensed more than 1 year from the original prescribed order.~~
 - ~~5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change shall be clearly indicated and initialed by the dispensing pharmacist.~~
- ~~E. A contractor shall monitor and ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~
- E. A contractor 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.

Arizona Administrative Register
Notices of Final Rulemaking

R9-22-210. Emergency Medical and Behavioral Health Services

- A.** Provision of and payment for emergency services. An emergency medical or behavioral health service is provided based on the prudent layperson standard to a member enrolled with a contractor by a licensed provider, registered with AHC-CCS to provide the services. Emergency services shall be provided under 42 U.S.C. 1396u-2.
- A.** For members enrolled with a contractor, AHCCCS contractors shall reimburse providers for emergency services as defined by and to the extent required by 42 USC 1396u-2.
- B.** Verification. A provider of emergency services shall verify a member's eligibility and enrollment status through the Administration to determine the need for notification to a contractor for a member, or the Administration for ~~an eligible person~~ a FFS member, and to determine the party responsible for payment of services rendered.
- C.** Access. A contractor shall ensure Aecess access to an emergency room; and emergency medical or behavioral health services, ~~shall which are~~ be available 24 hours per day, 7 seven days per week in each contractor's service area. The A contractor shall ensure that the use of an examining or a treatment room shall be is available ~~when~~ if required by a physician or a practitioner for the provision of emergency services.
- D.** Behavioral health evaluation. A behavioral health evaluation provided by a psychiatrist or a psychologist ~~shall be is~~ covered as an emergency service ~~as~~ under this Section if required to evaluate or stabilize an acute episode of mental disorder or substance abuse.
- E.** Prior authorization. An emergency service does not require prior authorization; however, a provider shall comply with the following notification requirements to a contractor:
1. A provider and a noncontracting provider furnishing emergency services to a member shall notify a member's contractor within 12 hours from the time a member presents for services;
 2. ~~A provider of emergency services for an eligible person is not required to notify the Administration; and~~
 - 3-2. If a member's medical condition is determined by the provider not to be an emergency medical condition ~~as defined in Article 1 of this Chapter~~, a provider shall:
 - a. Notify a the member's contractor before initiation of treatment; and
 - b. Follow the prior authorization requirements and protocol of a the contractor regarding treatment of a the member's ~~nonemergent nonemergency medical~~ condition. ~~Failure to provide timely notice or comply with prior authorization requirements of a contractor constitutes cause for denial of payment. Failure of the provider to obtain prior authorization is cause for denial.~~
- F.** Post-stabilization services. After a member's ~~emergent emergency medical~~ condition ~~has been is~~ stabilized, a provider ~~and~~ or a noncontracting provider shall request authorization from a the contractor for post-stabilization services under 42 U.S.C. 1396u-2.
- G.** A provider of emergency services for a FFS member is not required to notify the Administration.

R9-22-211. Transportation Services

- A.** Emergency ambulance services.
1. ~~Emergency ambulance transportation shall be is a covered service for a member or eligible person. Payment shall be is limited to the cost of transporting the member or eligible person in a ground or air ambulance:~~
 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 ~~or eligible person's~~ medical needs; and
 - b. ~~When no other means of transportation is both appropriate and available.~~
If no other appropriate means of transportation is available.
 2. ~~A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor, or the Administration for eligible persons, if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.~~
 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. ~~Determination of whether transport is medically necessary shall be based upon the medical condition of the member or eligible person at the time of transport.~~
 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 to notify the contractor may constitute cause for denial of claims. Failure of the provider to obtain prior authorization is cause for denial.~~

Arizona Administrative Register
Notices of Final Rulemaking

5. Notification to the Administration of emergency transportation provided to ~~an eligible person~~ a FFS member is not required, but the provider shall submit documentation with the claim which justifies the service.
- B.** ~~Medically necessary nonemergency transportation.~~
1. ~~As specified in contract, contractors shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange or pay for the member's own transportation to a service site or location if free transportation services are not available.~~
 2. ~~If an eligible person requires medically necessary non-emergency transportation due to an inability to arrange or pay for the services, or the services are not available at no cost, the attending physician or practitioner shall order those services.~~
- B.** The Administration or a contractor covers air ambulance services only if one or more of the criteria in subsection (B)(1), (2), or (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; or
 3. The medical condition of the member requires immediate:
 - 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.** ~~Air ambulance services shall be covered only if:~~
1. ~~The air ambulance transport is initiated upon the request of: an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;~~
 2. ~~The point of pickup: is: inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or eligible person or transporting the member or eligible person to the nearest hospital or other provider with appropriate facilities; and~~
 3. ~~The medical condition of the member or eligible person requires timely ambulance service and ground ambulance service will not suffice.~~
- C.** 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.** Meals, lodging, and escort services:
1. Expenses for meals, lodging, and transportation for a member or eligible person while en route to, or returning from, an approved and prior authorized health care service site out of the member's or eligible person's service area or county of residence shall be an AHCCCS covered service;
 2. Meals, lodging, and transportation expenses of an escort, who may be a family household member accompanying an eligible person or a member out of the eligible person's or member's service area, shall be covered if the services of the escort are ordered in writing by the member's primary care provider or the eligible person's attending physician or practitioner. A salary for an escort shall be covered if the escort is not a part of the eligible person's or member's family household.
- 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.** Limitations:
1. Family, household members, friends, and neighbors shall be reimbursed for providing transportation services only if:
 - a. The services are ordered in writing by the member's PCP or the eligible person's attending physician or practitioner; or
 - b. The services are authorized by the member's contractor or designee; and

- e. ~~Appropriate free transportation or public transportation is not available.~~
- 2. ~~A charitable organization routinely providing transportation services at no cost to ambulatory or chairbound persons shall not charge or seek reimbursement from the Administration or contractors for the provision of these services to a member or eligible person but may enter into subcontractual agreements with AHCCCS contractors for medically necessary transportation services provided to their members.~~
- 3. ~~Payment for meals, lodging, and transportation of an escort and a salary not to exceed the federal minimum wage shall be allowed only when the member or eligible person requires covered services that are not available in the service area. If the member or eligible person is admitted to an inpatient facility, meals, lodging, and a salary for the escort shall be covered only when accompanying the member or eligible person en route to, and returning from, the inpatient facility.~~
- 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.
 - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- F.G.** ~~Subject to A.R.S. § 36-2908(E) prior~~ A provider shall obtain prior ~~Prior~~ authorization from the Administration for transportation services provided for ~~eligible persons~~ a member ~~is required~~ for the following:
 - 1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system; and
 - 2. All meals, lodging, and services of an escort accompanying the ~~eligible person~~ member ~~under subsection (D)(2) 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.

R9-22-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices

- A.** ~~Medical supplies, durable medical equipment, and orthotic and prosthetic devices shall be~~ are covered services if provided in compliance with requirements of this Chapter, and
 - 1. ~~Prescribed for a member by the member's primary care provider or if prescribed by a physician or practitioner upon referral from the primary care provider unless referral is waived by the Administration; or~~
 - 2. ~~Prescribed by the attending physician or practitioner of an eligible person~~ the member; and
 - 3. ~~Provided in compliance with requirements of this Chapter.~~
 - 1. Prescribed by the primary care provider, attending physician, practitioner, or dentist;
 - 2. Prescribed by a specialist, upon referral from the primary care provider; attending physician, practitioner or dentist; and
 - 3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** ~~Medical supplies include consumable items covered under Medicare that are provided to a member or eligible person and that are not reusable.~~
- B.** Covered medical supplies are consumable items that are disposable and are essential for the member's health.
- C.** ~~Covered DME Medical equipment includes is any durable item, appliance, or piece of equipment that is; designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member or eligible person.~~
 - 1. Designed for a medical purpose.
 - 2. To withstand wear.
 - 3. Generally reusable by others, and
 - 4. Purchased or rented for a member.
- D.** ~~Covered Prosthetic prosthetic and orthotic devices include~~ are only those items that are essential for the habilitation or rehabilitation of a member ~~or eligible person.~~
- E.** ~~Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction;~~

Arizona Administrative Register
Notices of Final Rulemaking

~~F.E.~~ The following limitations on coverage apply:

1. ~~If medical equipment cannot be reasonably obtained from alternative resources at no cost, the~~ The medical equipment shall be DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the ~~equipment shall~~ DME does not exceed the cost of the equipment DME if purchased.
2. Reasonable repair or adjustment of purchased ~~medical equipment shall be~~ DME is covered if necessary to make the ~~equipment DME~~ serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. ~~Changes~~ A change in, or ~~additions~~ addition to, an original order for ~~medical equipment shall be~~ DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the Administration ~~or contractor for eligible persons~~, and ~~shall be~~ the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for ~~medical equipment DME~~ may be made after a claim for services ~~has been~~ is submitted to the member's contractor, or the Administration ~~for eligible persons~~, without prior written notification of the change or addition.
4. Reimbursement for Rental rental fees shall terminate:
 - a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member ~~or eligible person~~ no longer needs the ~~medical equipment DME~~;
 - b. ~~When~~ If the member ~~or eligible person~~ is no longer eligible for AHCCCS services; or
 - c. ~~When~~ If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the ~~Director~~ Administration.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming ~~shall not be~~ are not covered unless needed to treat a medical condition and; ~~provided in accordance with a prescription~~.
 - a. Prescribed by:
 - i. The member's primary care provider, attending physician, practitioner;
 - ii. A specialist upon referral from the primary care provider, attending physician, or practitioner; and
 - b. Authorized as required by the Administration, or contractor or its designee.
6. First aid supplies ~~shall not be~~ are not covered unless they are provided in accordance with a prescription.
7. Hearing aids ~~and prescriptive lenses shall not be~~ are not covered for ~~members or eligible persons who are~~ a member who is age 21 years of age and or older, unless authorized under subsection (E).
8. Prescriptive lenses are not covered for a member who is age 21 or older unless they are the sole visual prosthetic device used by the member after a cataract extraction.

~~G.~~ ~~Fee for service providers shall obtain prior authorization from the Administration before providing:~~

1. ~~Consumable medical supplies exceeding \$50.00 per month; or~~
2. ~~Durable medical equipment or prosthetic or orthotic devices for an eligible person for all rentals or if the cost to purchase the equipment or device exceeds \$200.00.~~

~~H.E.~~ Liability and ownership.

1. Purchased ~~durable medical equipment DME~~ provided to ~~members~~ a member but ~~which that~~ is no longer needed may be disposed of in accordance with each contractor's policy.
2. The ~~state~~ Administration shall retain title to purchased ~~durable medical equipment DME~~ supplied to ~~eligible persons~~ a member who ~~become~~ becomes ineligible or no longer ~~require~~ requires its use.
3. If customized ~~durable medical equipment DME~~ is purchased by the Administration ~~or contractor~~ for an ~~eligible person~~, or for a member by the contractor, the equipment ~~will~~ shall remain with the person during times of transition, or upon loss of eligibility.
 - a. For purposes of this Section, customized ~~durable medical equipment DME~~ refers to equipment that ~~has been~~ is altered or built to specifications unique to a member's ~~or eligible person's~~ medical needs and ~~which that~~, most likely, cannot be used or reused to meet the needs of another individual.
 - b. ~~Customized equipment obtained fraudulently by a member or an eligible person shall be returned for disposal to the member's contractor, or to the Administration, if the customized equipment was purchased for an eligible person.~~
 - b. A member shall return customized DME obtained fraudulently to the Administration or the contractor.

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

A. The following E.P.S.D.T. services ~~shall be~~ are covered for a member less than 21 years of age:

1. Screening services including:
 - a. Comprehensive health and developmental history;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Laboratory tests; and
 - e. Health education, including anticipatory guidance;
2. Vision services including:
 - a. Diagnosis and treatment for defects in vision;
 - b. Eye examinations for the provision of prescriptive lenses; and

Arizona Administrative Register
Notices of Final Rulemaking

- 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;
- 4. Dental services including:
 - a. Emergency dental services as specified in R9-22-207;
 - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
 - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
- 5. Orthognathic surgery;
- 6. Nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
- 7. Behavioral health services under 9 A.A.C. 22, Article 12;
- 8. Hospice services as follows:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
 - c. Hospice services do not include:
 - i. Medical services provided that are not related to the terminal illness; or
 - ii. Home delivered meals.
 - d. Hospice services that are provided and covered through Medicare are not covered by AHCCCS.
- ~~8-9.~~ Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5) or, April 1, 1990, incorporated by reference and on file with the Administration and the Office of Secretary of State. This incorporation by reference contains no future editions or amendments.
- B.** ~~All providers~~ Providers of E.P.S.D.T. services shall meet the following standards:
 - 1. Provide services by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
 - 2. Perform tests and examinations ~~in accordance with the AHCCCS Administration Periodicity Schedule.~~ 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.
 - a. ~~Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.~~
 - b. ~~Refer members as necessary for behavioral health evaluation and treatment services.~~
 - 3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
 - 4. Refer a member as necessary for behavioral health evaluation and treatment services.
- C.** ~~Contractors shall meet the following additional conditions for an E.P.S.D.T. members:~~
 - 1. ~~Provide information to a member, parent, or guardian concerning E.P.S.D.T. services;~~
 - 2. ~~Notify a member, parent, or guardian regarding the initiation of E.P.S.D.T. screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and~~
 - 3. ~~If requested, offer and provide necessary assistance with scheduling appointments for services and transportation to and from providers under R9-22-211.~~
- C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.
- D.** ~~Members with special health care needs shall be referred to CRS.~~
- D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

R9-22-215. Other Medical Professional Services

- A.** ~~The following medical professional services provided to a member by a contractor, or an eligible person through the Administration, shall be~~ are covered services when provided if a member receives these services in an inpatient, outpatient, or office setting within limitations specified below as follows:
 - 1. Dialysis;
 - 2. ~~Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:~~
 - 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications;
 - b. Supplies;
 - c. Devices; and
 - d. Surgical procedures.
 - 3. ~~Certified nurse midwife services provided by a certified nurse practitioner in midwifery;~~

Arizona Administrative Register
Notices of Final Rulemaking

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. Licensed midwife service for prenatal care and home births in low-risk pregnancies;~~
 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;
 - ~~5.6. Podiatry services when ordered by a member's primary care provider, or an eligible person's attending physician, or practitioner;~~
 - ~~6.7. Respiratory therapy;~~
 - ~~7.8. Ambulatory and outpatient surgery facilities services;~~
 - ~~8.9. Home health services under A.R.S. § 36-2907(D);~~
 - ~~9.10. Private or special duty nursing services when medically necessary and prior authorized;~~
 - ~~10.11. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy, and audiology within limitations in this Article in subsection (C);~~
 - ~~11.12. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and~~
 - ~~12.13. Inpatient Chemotherapy; chemotherapy; and~~
 14. Outpatient chemotherapy.
- B.** Prior authorization from the Administration for ~~eligible persons~~ a member is required for services listed in subsections (A)(4) through ~~(11)~~ (12).
- C.** The following ~~services shall be~~ are excluded as AHCCCS covered services:
1. Occupational and speech therapies provided on an outpatient basis for ~~members and eligible persons~~ a member age 21 years of age and or older;
 2. Physical therapy provided only as a maintenance regimen;
 3. Abortion counseling; or
 4. Services or items furnished solely for cosmetic purposes.

R9-22-216. NF, Alternative HCBS Setting, or HCBS

- A.** ~~Services provided in a NF, alternative HCBS setting as defined in R9-28-101, or HCBS as defined in 9 A.A.C. 28, Article 2 shall be R9-28-101 are~~ covered for a maximum of 90 days per contract year ~~if a medical condition of a member requires hospitalization of the member. if the member's medical condition would otherwise require hospitalization.~~
- B.** Except as otherwise provided in 9 A.A.C. 28, the following services ~~shall be~~ are not itemized for separate billing ~~excluded for purpose of separate billing~~ if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services including:
 - a. ~~Administration of~~ Administering medication,
 - b. Tube feedings,
 - c. Personal care services (assistance with bathing and grooming),
 - d. Routine testing of vital signs, and
 - e. Maintenance of ~~eatheters~~ catheter;
 2. Basic patient care equipment and sickroom supplies including:
 - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
 - b. Bathing and grooming supplies;
 - c. Identification ~~devices~~ device;
 - d. Skin ~~lotions~~ lotion;
 - e. Medication ~~cups~~ cup;
 - f. Alcohol wipes, cotton balls, and cotton rolls;
 - g. Rubber gloves (~~nonsterile~~ non-sterile);
 - h. Laxatives;
 - i. ~~Beds~~ Bed and accessories;
 - j. ~~Thermometers~~ Thermometer;
 - k. Ice bags;
 - l. Rubber sheeting;
 - m. Passive restraints;
 - n. Glycerin swabs;
 - o. Facial tissue;
 - p. Enemas;
 - q. Heating ~~pads~~ pad;

Arizona Administrative Register
Notices of Final Rulemaking

- r. Diapers; and
 - s. Alcoholic beverages;
 - 3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
 - 4. ~~Services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;~~
 - 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, state licensure standard, or county certification requirement;
 - 5. ~~Administrative physician~~ Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
 - 6. Physical therapy prescribed only as a maintenance regimen; and
 - 7. Assistive devices ~~and~~ or non-customized durable medical equipment.
- ~~C. Each admission shall be prior authorized by the Administration.~~
- C. A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 25. DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES**

PREAMBLE

- | | |
|------------------------------------|---------------------------------|
| <u>1. Sections Affected</u> | <u>Rulemaking Action</u> |
| R9-25-1201 | Amend |
- 2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
- Authorizing statutes: A.R.S. §§ 36-136(F), 36-2202(A), and 36-2209(A)
Implementing statutes: A.R.S. §§ 41-1072 through 41-1079, 36-2204, and 36-2212
- 3. The effective date of the rules:**
- May 9, 2002
- 4. A list of all previous notices appearing in the Register addressing the final rule:**
- Notice of Rulemaking Docket Opening: 8 A.A.R. 268, January 11, 2002
Notice of Proposed Rulemaking: 8 A.A.R. 394, February 1, 2002
Notice of Public Information: 8 A.A.R. 858, March 1, 2002
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
- | | |
|------------|---|
| Name: | Judi Crume, Bureau Chief |
| Address: | Arizona Department of Health Services, Bureau of Emergency Medical Services
1651 E. Morten, Suite 120
Phoenix, AZ 85020 |
| Telephone: | (602) 861-0708 |
| Fax: | (602) 861-9812 |
| E-mail: | jcrume@hs.state.az.us |
| or | |
| Name: | Kathleen Phillips, Rules Administrator |
| Address: | Arizona Department of Health Services
1740 W. Adams, Suite 102
Phoenix, AZ 85007 |
| Telephone: | (602) 542-1264 |
| Fax: | (602) 364-1150 |

Arizona Administrative Register
Notices of Final Rulemaking

E-mail: kphilli@hs.state.az.us

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

The proposed rulemaking amends A.A.C. R9-25-1201 to add time-frames for the Arizona Department of Health Services (the Department) to grant or deny basic life support certification and recertification, advanced life support certification and recertification, an extension to apply for basic or advanced life support recertification, and air ambulance registration and registration renewal. The rulemaking is necessary to ensure that the Department's licensing decisions under 9 A.A.C. 25, Articles 5 and 6, and 9 A.A.C. 13, Article 11 comply with A.R.S. §§ 41-1072 through 41-1079.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

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:

As required by A.R.S. §§ 41-1072 through 41-1079, this rule amendment establishes time-frames for the Department to grant or deny applications for emergency medical technician certification and recertification, and air ambulance registration and registration renewal. The time-frames require the Department to provide written notice at certain stages of the licensing decision-making process.

The rulemaking directly impacts over 11,000 currently certified emergency medical technicians, 15 air ambulance services which operate 70 registered air ambulances in Arizona, and the Department. The rulemaking also indirectly impacts thousands of emergency medical services patients served annually by these emergency medical technicians and air ambulances.

The overall economic impact of the rulemaking is expected to be minimal, with the benefits of the rulemaking outweighing the costs. There will be no new or additional costs to emergency medical technicians or to air ambulance services as a result of this rulemaking.

Cost Bearers

The new time-frames are consistent with the Department's current practices and may have only a minimal impact on emergency medical technicians, air ambulance services, and the Department. Should the Department fail to comply with licensing time-frames, the Department could be required to issue refunds and pay penalties as required by law. However, since the Department intends to comply with all time-frame requirements, it does not believe that this will occur.

Beneficiaries

The time-frames will benefit emergency medical technicians and air ambulance services by providing clarity in the licensing application process and assuring that the Department will process all applications in a fair, consistent, and timely manner.

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

No changes have been made in the text of the adopted rules from that in the proposed rules, except grammatical and organizational changes suggested by the staff of the Governor's Regulatory Review Council.

11. A summary of the principal comments and the agency response to them:

The Department did not schedule an oral proceeding on the proposed rulemaking and did not receive a written request for an oral proceeding. During the comment period of February 1, 2002 through the close of record on March 4, 2002, the Department did not receive any written or oral comments on the proposed rulemaking.

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:

None

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 25. DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES**

ARTICLE 12. TIME-FRAMES FOR DEPARTMENT APPROVALS

Section

R9-25-1201. ~~Ground Ambulance~~ Time-frames (A.R.S. §§ 41-1072 through 41-1079)

ARTICLE 12. TIME-FRAMES FOR DEPARTMENT APPROVALS

R9-25-1201. ~~Ground Ambulance~~ Time-frames (A.R.S. §§ 41-1072 through 41-1079)

- A. No change
- B. No change
- C. The substantive review time-frame described in A.R.S. § 41-1072(3) is listed in Table 1 and begins on the postmark date of the notice of administrative completeness.
 - 1. As part of the substantive review for approval of an initial or renewal ambulance certificate of registration, the Department or other Department-approved facility shall inspect the ~~ground ambulance vehicle~~ to be registered.
 - 2. No change
 - 3. If required under R9-25-502 or R9-25-602, the Department shall consider a request for an exception for good cause as part of the substantive review.
 - ~~3.4.~~ During the substantive review time-frame, the Department may make ~~± one~~ comprehensive written request for additional documents or information ~~or a~~ and it may make supplemental request by mutual written agreement requests for additional information with the applicant's written consent.
 - ~~4.5.~~ The time-frame for the Department to complete the substantive review and the overall time-frame are suspended from:
 - a. No change
 - b. No change
 - c. No change
 - ~~5.6.~~ The Department shall send a written notice of approval to an applicant who meets the qualifications in A.R.S. Title 36, Chapter 21.1 and this Chapter for the type of application submitted.
 - ~~6.7.~~ The Department shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S. Title 36, Chapter 21.1, and this Chapter for the type of application submitted.
- D. The Department shall consider an application withdrawn if within 60 days, or less if required by law, from the postmark date of a written notice or request for documents or information the applicant fails to supply the documents or information under subsections (B)(1) and ~~(C)(3)~~ (C)(4).
- E. An applicant that does not wish an application to be considered withdrawn may request a denial in writing within 60 days, or less if required by law, from the postmark date of a written notice or request for documents or information under subsection (B)(1) and ~~(C)(3)~~ (C)(4).
- F. No change

Arizona Administrative Register
Notices of Final Rulemaking

Table 1. Time-frames (in days)

Type of Approval Application	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
Initial Certificate of Necessity (R9-25-902)	A.R.S. §§ 36-2204, 36-2232, 36-2233, 36-2240	185	30	155
Provision of ALS Services (R9-25-902)	A.R.S. §§ 36-2232, 36-2233, 36-2240	185	30	155
Transfer of a Certificate of Necessity (R9-25-902)	A.R.S. §§ 36-2236(A) and (B), 36-2240	185	30	155
Renewal of a Certificate of Necessity (R9-25-904)	A.R.S. §§ 36-2233, 36-2235, 36-2240	60	15	45
Amendment of a Certificate of Necessity (R9-25-905)	A.R.S. §§ 36-2232(A)(4), 36-2240	185	30	155
Initial Registration of a Ground Ambulance Vehicle (R9-25-1001)	A.R.S. §§ 36-2212, 36-2232, 36-2240	60	15	45
Renewal of a Ground Ambulance Vehicle Registration (R9-25-1001)	A.R.S. §§ 36-2212, 36-2232, 36-2240	60	15	45
Establishment of Initial General Public Rates (R9-25-1101)	A.R.S. §§ 36-2232, 36-2239	185	30	155
Adjustment of General Public Rates (R9-25-1102)	A.R.S. §§ 36-2234, 36-2239	185	30	155
Contract Rate or Range of Rates Less than General Public Rates (R9-25-1103)	A.R.S. §§ 36-2234, 36-2239	185	30	155
Ground Ambulance Service Contracts (R9-25-1104)	A.R.S. §§ 36-2232	90	30	60
Ground Ambulance Service Contracts with Political Subdivisions (R9-25-1104)	A.R.S. §§ 36-2232, 36-2234(K)	30	15	15
Subscription Service Rate (R9-25-1105)	A.R.S. § 36-2232(A)(1)	185	30	155
<u>Basic Life Support Certification (R9-25-501)</u>	<u>A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1) and (6)</u>	<u>90</u>	<u>15</u>	<u>75</u>
<u>Basic Life Support Recertification (R9-25-510)</u>	<u>A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1), (4), and (6)</u>	<u>90</u>	<u>15</u>	<u>75</u>
<u>Extension to File a Recertification Application (R9-25-512 and R9-25-612)</u>	<u>A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1)</u>	<u>45</u>	<u>15</u>	<u>30</u>
<u>Advanced Life Support Certification (R9-25-601)</u>	<u>A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1) and (6)</u>	<u>90</u>	<u>15</u>	<u>75</u>
<u>Advanced Life Support Recertification (R9-25-610 and R9-25-611)</u>	<u>A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1), (4), and (6)</u>	<u>90</u>	<u>15</u>	<u>75</u>
<u>Air Ambulance Registration Certificate (R9-13-1101)</u>	<u>A.R.S. § 36-2212</u>	<u>60</u>	<u>15</u>	<u>45</u>

<u>Air Ambulance Registration Certificate Renewal (R9-13-1101)</u>	<u>A.R.S. § 36-2212</u>	<u>60</u>	<u>15</u>	<u>45</u>
--	-------------------------	-----------	-----------	-----------

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM**

PREAMBLE

- 1. Sections Affected**

<u>Sections Affected</u>	<u>Rulemaking Action</u>
R9-28-101	Amend
R9-28-201	Amend
R9-28-202	Amend
R9-28-204	Amend
R9-28-205	Amend
R9-28-206	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. § 36-2932
Implementing statutes: A.R.S. §§ 36-2907, 36-2932, 36-2939
- 3. The effective date of the rules:**

May 9, 2002
- 4. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 7 A.A.R. 5262, November 23, 2001
Notice of Proposed Rulemaking: 8 A.A.R. 214, January 11, 2002
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Cheri Tomlinson, Federal and State Policy Administrator
Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034
Telephone: (602) 417-4534
Fax: (602) 256-6756
- 6. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Administration made changes to 9 A.A.C. 28 to provide additional clarity and conciseness to existing rule language. These changes impact two Articles:

 - Article 1, Definitions (R9-28-101 and R9-28-102), and
 - Article 2, Scope of Services (R9-28-201 through R9-22-206).

Following is an explanation of the changes:

9 A.A.C. 28, Article 1, Definitions

The Administration modified, added, or deleted definitions to improve the clarity and conciseness of the rule language.

9 A.A.C. 28, Article 2, Scope of Services

R9-28-201	The Administration made minor changes to improve clarity.
R9-28-202	The Administration made minor changes to improve clarity.
R9-28-204	The Administration amended the content of this Section to improve the clarity and conciseness of the rule language and clarify where institutional services may be provided as well as the limitations.
R9-28-205	The Administration added "private duty nursing services" as a covered service.

Arizona Administrative Register

Notices of Final Rulemaking

R9-28-206 The Administration amended “ventilator dependent services” by striking “private duty nursing services”, as this is a service available to other members who receive home and community based services (HCBS).

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

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 contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define the scope of services for AHCCCS’ long term care program. The Administration is amending these rules to make the rules more clear, concise, and understandable by:

- Grouping like concepts to provide clarity and conciseness to the rule language,
- Clarifying language that does not clearly present policies or procedures, and
- Updating citations to documents incorporated in the rule, as needed.

As of April 2002, there are 33,788 members enrolled in Arizona’s Long Term Case program known as “ALTCS”. The members may choose from eight contracted Program contractors. Native American members may opt for a Program contractor or the IHS system. In R9-28-206, the Administration added “private duty nursing” as a service for all members and deleted the Section that had “private duty nursing” limited to ventilator dependent members to reflect current practice. The Administration believes that this action has had a nominal impact on its budget, as well as the Program contractors’. Due to this change, the Administration and Program contractors were able to avert member institutionalization and hospitalization. This action has been cost effective overall and improved member satisfaction by the member’s ability to stay at home. This has had a positive impact on the provider agencies due to the increase in demand for nursing services.

The amendments are primarily made to make the rules more clear, concise, and understandable. Nominal impact is anticipated. The small business community as a whole is not impacted by the clarifications. All affected entities benefit from the additional clarity and conciseness of the rule language. AHCCCS and contractors are directly affected by and benefit from the clarifications.

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

1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes per G.R.R.C. staff suggestions.
----	---------	--

11. A description of the principal comments and the agency response to them.

The principal comments received by the Administration during the comment period and at public hearings are listed below:

1.	R9-28-101-102	AHCCCS deleted numbering system for definitions. The commentor opposes the deletion of numbers in R9-22-102 because “New definitions are not added with any frequency.” The Administration should consider reinstating the numbering system in all definition sections. (Gammage and Burnham)	DISAGREE Definitions are in alphabetical order versus numerical order. AHCCCS adds, deletes or amends the definition sections with almost every rule package. It is cumbersome for AHCCCS to have to renumber each time. It is more time efficient to have the definitions in alphabetical order and it is allowable per the Secretary of State’s Office.
----	---------------	---	---

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

Arizona Administrative Register
Notices of Final Rulemaking

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

- 42 CFR 418.202, December 20, 1994, R9-28-206
- 42 CFR 441.151, May 22, 2001, R9-28-204
- 42 CFR 483, Subpart I, February 28, 1992, R9-28-204

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM**

ARTICLE 1. DEFINITIONS

Section

R9-28-101. General Definitions

ARTICLE 2. COVERED SERVICES

Section

R9-28-201. General Requirements

R9-28-202. Medical Services

R9-28-204. Institutional Services

R9-28-205. Home and Community Based Services (HCBS)

R9-28-206. ALTCS Services that may be Provided to ~~Members or Eligible Persons~~ a Member Residing in either an Institutional or HCBS ~~Settings~~ Setting

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
“Administration”	A.R.S. § 36-2931
“ADHS”	R9-22-112
“Aggregate”	R9-22-107
“AHCCCS”	R9-22-101
“ <u>AHCCCS Registered Provider</u> ”	<u>R9-22-101</u>
“Algorithm”	R9-28-104
“ALTCS”	R9-28-101
“ALTCS acute care services”	R9-28-104
“Alternative HCBS setting”	R9-28-101
“Ambulance”	R9-22-102
“Bed hold”	R9-28-102
“Behavior intervention”	R9-28-102
“Behavior management services”	R9-20-101
“Behavioral health evaluation”	R9-22-112
“Behavioral health medical practitioner”	R9-22-112
“Behavioral health professional”	R9-20-101
“Behavioral health service”	R9-20-101
“Behavioral health technician”	R9-20-101
“Billed charges”	R9-22-107
“Board-eligible for psychiatry”	R9-22-112
“Capped fee-for-service”	R9-22-101
“Case management plan”	R9-28-101
“Case manager”	R9-28-101
“Case record”	R9-22-101
“Categorically-eligible”	R9-22-101
“Certification”	R9-28-105
“Certified psychiatric nurse practitioner”	R9-22-112
“CFR”	R9-28-101

Arizona Administrative Register
Notices of Final Rulemaking

“Clean claim”	R9-20-101
“Clinical supervision”	R9-22-112
“CMS”	R9-22-101
“Community Spouse”	R9-28-104
“Contract”	R9-22-101
<u>“Contract year”</u>	<u>R9-28-101</u>
“Contractor”	A.R.S. § 36-2901
“County of fiscal responsibility”	R9-28-107
“Covered services”	R9-22-102 <u>R9-28-101</u>
“CPT”	R9-22-107
“CSRD”	R9-28-104
“Day”	R9-22-101
“Department”	A.R.S. § 36-2901
“De novo hearing”	42 CFR 431.201
“Developmental disability”	A.R.S. § 36-551
“Diagnostic services”	R9-22-102
“Director”	R9-22-101
“Disenrollment”	R9-22-117
“DME”	R9-22-102
“EPD”	R9-28-301
“Eligible person”	A.R.S. § 36-2931
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107
“Enrollment”	R9-22-117
“Estate”	A.R.S. § 14-1201
“Facility”	R9-22-101
“Factor”	R9-22-101
“Fair consideration”	R9-28-104
“FBR”	R9-22-101
“Grievance”	R9-22-108
“GSA”	R9-22-101
“Guardian”	R9-22-116
“Home and community based services” (HCBS)	
<u>“HCBS” or “Home and community based services”</u>	A.R.S. §§ 36-2931 and 36-2939
“Health care practitioner”	R9-22-112
“Hearing”	R9-22-108
“Home”	R9-28-101
“Home health services”	R9-22-102
“Hospital”	R9-22-101
“Intermediate care facility for the mentally retarded” (“ICF-MR”)-	42 CFR 440.150
<u>“ICF-MR” or “Intermediate care facility for the mentally retarded”</u>	<u>42 CFR 483 Subpart I</u>
“IHS”	R9-28-101
“IMD”	42 CFR 435.1009 and R9-28-111
“Indian”	42 CFR 36.1
“Institutionalized”	R9-28-104
“Interested Party”	R9-28-106
“JCAHO”	R9-28-101
“License” or “licensure”	R9-22-101
“Medical record”	R9-22-101
“Medical services”	R9-22-101
“Medical supplies”	R9-22-102
“Medically eligible”	R9-28-104
“Medically necessary”	R9-22-101
“Member”	A.R.S. § 36-2931
“Mental disorder”	A.R.S. § 36-501
“MMMNA”	R9-28-104
“Nursing facility” <u>or</u> (“NF”)	42 U.S.C. 1396r(a)

Notices of Final Rulemaking

“Noncontracting provider”	A.R.S. § 36-2931
“Occupational therapy”	R9-22-102
“Partial care”	R9-22-112
“PAS”	R9-28-103
“PASARR”	R9-28-103
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Post-stabilization services”	42 CFR 438.114
“Practitioner”	R9-22-102
“Primary care provider”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Prior period coverage” <u>or</u> (“PPC”)	R9-22-107
“Private duty nursing services”	R9-22-102
“Program contractor”	A.R.S. § 36-2931
“Provider”	A.R.S. § 36-2931
“Psychiatrist”	R9-22-112
“Psychologist”	R9-22-112
“Psychosocial rehabilitation”	R9-20-101
“Quality management”	R9-22-105
“Regional behavioral health authority” <u>or</u> (“RBHA”)	A.R.S. § 36-3401
“Radiology”	R9-22-102
“Reassessment”	R9-28-103
“Redetermination”	R9-28-104
“Referral”	R9-22-101
“Reinsurance”	R9-22-107
“Representative”	R9-28-104
“Respiratory therapy”	R9-22-102
“Respite care”	R9-28-102
“RFP”	R9-22-106
“Room and board”	R9-28-102
“Scope of services”	R9-22-102
“Section 1115 Waiver”	A.R.S. § 36-2901
“Speech therapy”	R9-22-102
“Spouse”	R9-28-104
“SSA”	42 CFR 1000.10
“SSI”	R9-22-101
“Subcontract”	R9-22-101
“Utilization management”	R9-22-105
“Ventilator dependent”	R9-28-102

B. General definitions. ~~The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:~~ General definitions. In addition to definitions contained in A.R.S. §§ 36-551, 36-2901, 36-2931, and 9 A.A.C. 22, Article 1, the following words and phrases have the following meanings unless the context of the Chapter explicitly requires another meaning:

“ALTCS” means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

“Alternative HCBS setting” means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:

For a person with a developmental disability (~~DD~~) specified in A.R.S. § 36-551:

- Community residential setting defined in A.R.S. § 36-551;
- Group home defined in A.R.S. § 36-551;
- State-operated group home under A.R.S. § 36-591;
- Family foster home under 6 A.A.C. 5, Article 58;
- Group foster home under R6-5-5903;
- Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;
- Adult therapeutic foster home under 9 A.A.C 20, Articles 1 and 15; ~~and~~
- Level I and Level II behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

Arizona Administrative Register
Notices of Final Rulemaking

Rural substance abuse transitional agencies under 9 A.A.C. 20, Articles 1 and 14.

For a person who is elderly or physically disabled (~~EPD~~) under R9-28-301, and the facility, setting, or institution is registered with AHCCCS:

Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;
Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;
Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;
Adult therapeutic foster home under 9 A.A.C. 20, Articles 1 and 15;
Level I and Level II behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6;
Rural Substance Abuse Transitional Agencies under 9 A.A.C. 20, Articles 1 and 14; and
Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35 as amended by Laws 2001, Ch. 140, § 1.

"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.

"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of two years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.

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

"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.

"Covered Services" means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.

"Home" means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to a member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion ~~and of~~ any of these; that is licensed or certified by a regulatory agency of the state as a:

Health care institution under A.R.S. § 36-401;
Residential care institution under A.R.S. § 36-401;
Community residential setting under A.R.S. § 36-551; or
Behavioral health service under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

"IHS" means the Indian Health Service.

"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

ARTICLE 2. COVERED SERVICES

R9-28-201. General Requirements

In addition to the exclusions and limitations specified in this Article, ~~ALTCS services~~ provided to a member are covered services if: shall be:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. ~~Prior authorized~~ The provider obtains prior authorization as required by an eligible person or a member's program contractor or by the Administration, when this authorization is required:
 - a. ~~Services may be denied if required prior authorization is not obtained.~~ Failure of the provider to obtain prior authorization is cause for denial.
 - b. ~~Services provided during a retroactive period of eligibility~~ prior period coverage are exempt from prior authorization requirements;
4. Provided in facilities or areas of facilities; that are licensed or certified according to under Article 5 of this Chapter, or meet other requirements described in Article 5 of this Chapter;
5. ~~Rendered by providers registered with the Administration as authorized to provide the service~~ Rendered by AHCCCS registered providers as permitted under this Chapter and within their scope of practice; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

R9-28-202. Medical Services

The Administration ~~and its contractors or a contractor~~ shall cover medical services ~~and provisions~~ specified in 9 A.A.C. 22, Article 2 ~~and Article 12 for a ALTCS members and eligible persons member~~, subject to the limitations and exclusions specified in ~~those Articles~~ Article 2, unless otherwise specified in this Chapter.

R9-28-204. Institutional Services

A. Institutional services ~~shall be~~ are provided in:

1. A ~~nursing facility NF under R9-28-101;~~
2. An "ICF-MR" ~~under R9-28-101;~~ or

Arizona Administrative Register
Notices of Final Rulemaking

- ~~3. An "IMD" under R9-28-101.~~
 3. A facility identified in R9-28-1105(A)(1)(b), (B), or (C).
- B.** The Administration and ~~its contractors~~ a contractor shall include the following services in the per diem rate for ~~these facilities~~ a facility listed in subsection (A):
1. Nursing care services;
 2. Rehabilitative services prescribed as a maintenance regimen;
 3. Restorative services, such as range of motion;
 4. Social services;
 5. Nutritional and dietary services;
 6. Recreational therapies and activities;
 7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
 8. Overall management and evaluation of a member's ~~or eligible person's~~ care plan;
 9. Observation and assessment of a member's ~~or eligible person's~~ changing condition;
 10. Room and board services, including, ~~but not limited to~~, supporting services such as food and food preparation, personal laundry, and housekeeping;
 11. Non-prescription; and stock pharmaceuticals; and
 12. Respite care services not to exceed 30 days per contract year.
- C.** Each facility ~~shall be listed in subsection (A)~~ is responsible for coordinating the delivery of at least the following auxiliary services:
1. Under 9 A.A.C. 22, Article 2:
 - a. ~~Medical services~~ Attending physician, practitioner, and primary care provider services;
 - b. Pharmaceutical services;
 - c. Diagnostic services under R9-22-208;
 - d. Emergency medical services; and
 - e. Emergency and medically necessary transportation services.
 2. Therapy services; under R9-28-206.
- D.** Limitations. The following limitations apply:
1. A private room in a nursing facility NF, ICF-MR, or IMD facility identified in R9-28-1105(A)(1)(b), (B), or (C) shall place a member or eligible person in a private room is covered only if:
 - a. The member or eligible person has a medical condition that requires isolation, and
 - b. The member's ~~or eligible person's~~ primary care provider or attending physician ~~gives~~ provides written authorization;
 2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR, ~~Part~~ 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
 3. ~~Convalescent care shall be excluded as a covered service for members and eligible persons specified in A.R.S. Title 36, Chapter 29, Article 1;~~
 - ~~4.3.~~ Bed hold days for the Administration's as authorized by the Administration or its designee for a fee-for-service providers provider shall meet the following criteria:
 - a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS contract year, and is available ~~when an eligible person~~ if a member is admitted to a hospital for a short stay. After the short-term hospitalization, the ~~eligible person member~~ member is returned to the institutional facility from which leave ~~was~~ is taken, and to the same bed if the level of care required can be provided in that facility bed; and
 - b. Therapeutic leave for a member age 21 and older is limited to ~~9~~ nine days per AHCCCS contract year. A physician order is required for therapeutic leave from the facility for ~~4~~ one or more overnight stays to enhance psychosocial interaction, or as a trial basis for discharge planning. After the therapeutic leave, the ~~eligible person member~~ member is returned to the same bed within the institutional facility;
 - c. ~~A combination of therapeutic leave and bedhold days, totaling no more than 21 days per contract year, may be taken by a member under 21 years of age. Therapeutic leave and short-term hospitalization leave are limited to any combination of 21 days per contract year for a member under age 21;~~
 - ~~5.4.~~ The Administration or ~~its contractors~~ a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's ~~or eligible person's~~ case manager or the case manager's designee if:
 - a. The services are ordered by the member's ~~or eligible person's~~ primary care provider; and
 - b. The services are specified in a case management plan under R9-28-510;
 5. A member age 21 through 64 is eligible for behavioral health services provided in a facility under subsection (A)(3) that has more than 16 beds, for up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified by 42 CFR 441.151, May 22,

Arizona Administrative Register
Notices of Final Rulemaking

2001, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and

6. The limitations in subsection (D)(5) do not apply to a member:
- a. Under age 21 or age 65 or over, or
 - b. In a facility with 16 beds or less.

R9-28-205. Home and Community Based Services (HCBS)

- A. Subject to the availability of federal funds, HCBS are covered services ~~when if~~ provided to a member ~~or eligible person~~ residing in a ~~HCBS setting~~ the member's own home or an alternative residential setting. Room and board services are not covered in a HCBS setting.
- B. The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or ~~eligible person~~ in accordance with R9-28-510.
- C. Home and community based services ~~shall~~ include the following:
1. Home health services provided on a part-time or intermittent basis. These services include:
 - a. Nursing care;
 - b. Home health aide;
 - c. Medical supplies, equipment, and appliances;
 - d. Physical therapy;
 - e. Occupational therapy;
 - f. Respiratory therapy; and
 - g. Speech and audiology services;
 2. Private duty nursing services;
 - ~~2.3.~~ Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
 - ~~3.4.~~ Transportation services to obtain ~~ALTCS~~ covered medically necessary services;
 - ~~4.5.~~ Adult day health services provided to a member ~~or eligible person who is not developmentally disabled as defined by A.R.S. § 36-551~~, in an adult day health care facility licensed ~~according to~~ under 9 A.A.C. 10, Article 5, including:
 - a. ~~Planned care supervision and activities~~ Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Personal living skills training;
 - d. Meals and health monitoring;
 - e. Preventive, therapeutic, and restorative health related services; and
 - f. Behavioral health services, provided either directly or through referral, if medically necessary;
 - ~~5.6.~~ Personal care services;
 - ~~6.7.~~ Homemaker services;
 - ~~7.8.~~ Home delivered meals, ~~which that~~ provide at least ~~1/3~~ one-third of the recommended dietary allowance, for a member ~~or eligible person who is not developmentally disabled as defined in~~ does not have a developmental disability under A.R.S. § 36-551;
 - ~~8.9.~~ Respite care services for no more than 720 hours per contract year;
 - ~~9.10.~~ Habilitation services including:
 - a. Physical therapy;
 - b. Occupational therapy;
 - c. Speech and audiology services;
 - d. Training in independent living;
 - e. Special development skills that are unique to the member;
 - f. Sensory-motor development;
 - g. Behavior intervention; and
 - h. Orientation and mobility training;
 - ~~10.11.~~ Developmentally disabled day care ~~for an eligible person or a member who is developmentally disabled, as defined by under A.R.S. § 36-551~~, provided in a group setting during a portion of a 24-hour period, ~~and to include~~ including:
 - a. ~~Planned care supervision and activities~~ Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Activities of daily living skills training; and
 - d. Habilitation services; and
 - ~~11.12.~~ Supported employment services ~~provided to a member or eligible person who is an ALTCS transitional developmentally disabled HCBS person as defined by A.R.S. § 36-551 and in R9-28-306~~. Supported employment services provided to a member in the ALTCS transitional program under R9-28-306 who is developmentally disabled under A.R.S. § 36-551.

Arizona Administrative Register
Notices of Final Rulemaking

R9-28-206. ALTCS Services that may be Provided to ~~Members or Eligible Persons~~ a Member Residing in either an Institutional or HCBS Setting

The Administration shall cover the following ALTCS services ~~when~~ if the services are provided to a member ~~or eligible person~~ within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
 - a. ~~The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's or eligible person's primary care provider or attending physician;~~
 - b. ~~These therapies and services are~~ The therapy or service is authorized by the member's ~~program~~ contractor or the Administration ~~for an eligible person;~~ and
 - c. ~~These therapies and services are~~ The therapy or service is included in the member's ~~or eligible person's~~ case management plan.
2. Medical supplies, durable medical equipment, and customized durable medical equipment; which
 - a. ~~These supplies or equipment conform with the requirements and limitations of 9 A.A.C. 22, Article 2;~~ and
 - b. ~~For billing purposes, supplies and equipment are limited to items not included by the Administration under the rates in Article 7 of this Chapter for the providers of the services.~~
3. ~~Ventilator dependent services:~~
 - a. ~~Inpatient or institutional services for a ventilator dependent member are limited to services provided in a general hospital, special hospital, nursing facility, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate; or~~
 - b. ~~In addition to authorized home and community based services specified in this Section, private duty nursing services are covered only for a ventilator dependent member or eligible person residing in a HCBS setting.~~
3. Ventilator dependent services:
 - a. Inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate under 9 A.A.C. 22, Article 7;
 - b. A ventilator dependent member may receive the array of home and community based services under R9-28-205 as appropriate.
4. Hospice services:
 - a. Hospice services are covered only for a member ~~or eligible person~~ who is in the final stages of a terminal illness and has a prognosis of death within ~~6~~ six months;
 - b. ~~Services Covered hospice services for available to a member or eligible person receiving hospice care are limited to those allowable under 42 CFR Part 418 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no further future editions or amendments; and~~
 - c. ~~Hospice Covered hospice services are inclusive except for~~ do not include:
 - i. ~~Medical services provided that are not related to the terminal illness; or~~
 - ii. ~~Home delivered meals;~~ and
 - iii. ~~Hospice services that are provided and covered through Medicare.~~
 - d. Medicare is the primary payor of hospice services for a member if applicable.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CHILDREN'S HEALTH INSURANCE PROGRAM**

PREAMBLE

1. Sections Affected

Rulemaking Action

R9-31-101	Amend
R9-31-201	Amend
R9-31-204	Amend
R9-31-205	Amend
R9-31-207	Amend
R9-31-208	Amend
R9-31-209	Amend
R9-31-212	Amend
R9-31-215	Amend
R9-31-216	Amend
R9-31-1603	Amend
R9-31-1608	Amend
R9-31-1611	Amend
R9-31-1612	Amend
R9-31-1613	Amend
R9-31-1614	Amend
R9-31-1617	Amend

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

Authorizing statutes: A.R.S. §§ 36-2982, 36-2986, 36-2988 and 36-2989

Implementing statutes: A.R.S. §§ 36-2982, 36-2986, 36-2988, and 36-2989

3. The effective date of the rules:

May 9, 2002

4. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 5264, November 23, 2001

Notice of Proposed Rulemaking: 8 A.A.R. 224, January 11, 2002

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS

Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

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

The Administration made changes to 9 A.A.C. 31 to conform to state statute and federal law to provide additional clarity and conciseness to existing rule language. These changes impact three Articles:

- Article 1, Definitions (R9-31-101),
- Article 2, Scope of Services (R9-31-201, R9-31-204, R9-31-205, R9-31-207 through R9-31-209, R9-31-212, R9-31-215, and R9-31-216), and
- Article 16, Services for Native Americans (R9-31-1603, R9-31-1608, R9-31-1611 through 1614, and R9-31-1617)

Following is an explanation of the changes:

9 A.A.C. 31, Article 1, Definitions

The Administration modified, added, or deleted definitions to improve the clarity and conciseness of the rule language.

R9 A.A.C. 31, Article 2, Scope of Services

- | | |
|-----------|---|
| 9-31-201 | The Administration amended the content of this Section to improve the clarity and conciseness of the rule language. |
| R9-31-204 | The Administration made minor changes to improve clarity. |
| R9-31-205 | The Administration made minor changes to improve clarity. |
| R9-31-207 | The Administration made minor changes to improve clarity. |
| R9-31-208 | The Administration struck the language and refers to R9-22-208 and A.R.S. § 36-2989 for content. |
| R9-31-209 | The Administration struck the language and refers to R9-22-209 for content. |
| R9-31-212 | The Administration made minor changes to improve clarity. |
| R9-31-215 | The Administration deleted chiropractic services in subsection (B)(3). |
| R9-31-216 | The Administration made minor changes to improve clarity. |

9 A.A.C. 31, Article 16, Services for Native Americans

- | | |
|------------|--|
| R9-31-1603 | The Administration amended the content of this Section to improve the clarity and conciseness of the rule language and conform to federal law (subsection (B)). |
| R9-31-1608 | The Administration made minor changes to improve clarity and deleted subsections (C)(4) and (5) as these areas are covered under A.R.S. Title 32. |
| R9-31-1611 | The Administration made minor changes to improve clarity and deleted subsection (G). The deletion will allow the Administration to work with fee-for-service (FFS) providers in raising the threshold point at which prior authorization (PA) is needed for medical supplies and durable medical equipment. This makes the PA process less burdensome for the FFS providers. |
| R9-31-1612 | The Administration amended vision services to conform to state statute in subsection (A)(2) and added the following references: 42 CFR 441 Subpart B and A.A.C. R9-7-301 for content. |
| R9-31-1613 | The Administration added exclusions to Title XXI covered services to mirror R9-31-215. |
| R9-31-1614 | The Administration made minor changes to improve clarity. |
| R9-31-1617 | The Administration struck language duplicative of R9-31-1603. |

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

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 contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define the scope of services for AHCCCS' KidsCare program. The Administration is amending these rules to make the rules more clear, concise, and understandable by:

- Grouping like concepts to provide clarity and conciseness to the rule language,
- Clarifying language that does not clearly present policies or procedures, and
- Updating citations to documents incorporated in the rule, as needed.

Arizona Administrative Register

Notices of Final Rulemaking

As of April 2002, there are 48,879 members enrolled in Arizona’s SCHIP program known as “KidsCare”. There are ten contracted health plans from which members may choose. Native American members may opt for a contracted health plan or the IHS system.

The amendments are primarily made to make the rules more clear, concise, and understandable. The change made in R9-31-1612(B)(2) which changed “Administration’s Periodicity Schedule” to “under 42 CFR 441 Subpart B, January 29, 1985” has neutral impact. This is because the CFR citation gives the states the discretion in framing the EPSDT services which includes the periodicity schedule.

Nominal impact is anticipated. The small business community as a whole is not impacted by the clarifications. All affected entities benefit from the additional clarity and conciseness of the rule language. AHCCCS and contractors are directly affected by and benefit from the clarifications.

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

1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules at the suggestion of G.R.R.C. staff.
----	---------	--

11. A description of the principal comments and the agency response to them.

The Administration received no oral or written comments prior to close of record at 5:00 p.m. on February 12, 2001.

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:

42 CFR 441, Subpart B, January 29, 1985, R9-31-1612

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 1. DEFINITIONS

Section

R9-31-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section

R9-31-201. General Requirements

R9-31-204. Inpatient General Hospital Services

R9-31-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Attending Physician, Practitioner, and Primary Care Provider Services

R9-31-207. Dental Services

R9-31-208. Laboratory, Radiology, and Medical Imaging Services

R9-31-209. Pharmaceutical Services

R9-31-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices

R9-31-215. Other Medical Professional Services

R9-31-216. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS

Arizona Administrative Register
Notices of Final Rulemaking

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section

- R9-31-1603. Inpatient General Hospital Services
- R9-31-1608. Pharmaceutical Services
- R9-31-1611. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices
- R9-31-1612. Health Risk Assessment and Screening Services
- R9-31-1613. Other Medical Professional Services
- R9-31-1614. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS
- R9-31-1617. Prior Authorization

ARTICLE 1. DEFINITIONS

R9-31-101. Location of Definitions

A. Location of definitions. Definitions applicable to 9 A.A.C. 31 are found in the following.

Definition	Section or Citation
“Accommodation”	R9-31-113
“Acute mental health services”	R9-22-112
“ADHS”	R9-31-112
“Administration”	A.R.S. § 36-2901
“Adverse action”	R9-31-108
“Aggregate”	R9-22-107
“AHCCCS”	R9-31-101
“AHCCCS registered provider”	R9-31-101 <u>R9-22-101</u>
“Ambulance”	R9-22-102
“Ancillary department”	R9-22-107
“Applicant”	R9-31-101
“Application”	R9-31-101
“Behavior management service”	R9-31-112
“Behavioral health professional”	R9-31-112
“Behavioral health evaluation”	R9-31-112
“Behavioral health medical practitioner”	R9-31-112
“Behavioral health service”	R9-31-112
“Behavioral health technician”	R9-31-112
“Billed charges”	R9-22-107
“Board-eligible for psychiatry”	R9-31-112
“Capital costs”	R9-22-107
“Certified nurse practitioner”	R9-31-102
“Certified psychiatric nurse practitioner”	R9-31-112
“Child”	42 U.S.C. 1397jj
“Chronically ill”	A.R.S. § 36-2983
“Clean claim”	A.R.S. § 36-2904
“Clinical supervision”	R9-31-112
“CMDP”	R9-31-103
“Continuous stay”	R9-22-101
“Contract”	R9-22-101
“Contractor”	A.R.S. § 36-2901
“Contract year”	R9-31-101
“Copayment”	R9-22-107
“Cost avoidance”	R9-31-110
“Cost-to-charge ratio”	R9-22-107
“Covered charges”	R9-31-107
“Covered services”	R9-22-102
“CPT”	R9-22-107
“CRS”	R9-31-103
“Date of action”	R9-31-113
“Day”	R9-22-101
“Denial”	R9-31-113
“De novo hearing”	R9-31-112 <u>42 CFR 431.201</u>
“Dentures”	R9-22-102
“DES”	R9-31-103

Arizona Administrative Register

Notices of Final Rulemaking

“Determination”	R9-31-103
“Diagnostic services”	R9-22-102
“Director”	A.R.S. § 36-2981
“DME”	R9-22-102
“DRI inflation factor”	R9-22-107
“Emergency medical condition”	42 U.S.C. 1396b(v)
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107
“Enrollment”	R9-31-103
“Evaluation”	R9-31-112
<u>“Experimental services”</u>	<u>R9-22-101</u>
“Facility”	R9-22-101
“Factor”	R9-22-101
“First-party liability”	R9-22-110
“FPL”	A.R.S. § 36-2981
“Grievance”	R9-22-108
“Group Health Plan”	42 U.S.C. 1397jj
“GSA”	R9-22-101
“Guardian”	R9-22-103
“Head of Household”	R9-31-103
“Health care practitioner”	R9-31-112
“Hearing”	R9-22-108
“Hearing aid”	R9-22-102
“Home health services”	R9-22-102
<u>“Hospital”</u>	<u>R9-22-101</u>
“Household income”	R9-31-103
“Hospital”	R9-31-103
“ICU”	R9-22-107
“IGA”	R9-31-116
“IHS”	R9-31-116
“IHS” or “Tribal Facility Provider”	R9-31-116
“Information”	R9-31-103
“IMD”	<u>42 CFR 435.1009 and</u> R9-31-112
“Inmate of a public institution”	42 CFR 435.1009
“Inpatient hospital services”	R9-31-101
“License” or “licensure”	R9-22-101
“Medical record”	R9-22-101
“Medical review”	R9-31-107
“Medical services”	R9-22-101
“Medical supplies”	R9-22-101
“Member”	A.R.S. § 36-2981
“Mental disorder”	R9-31-112
“Native American”	R9-31-101
“New hospital”	R9-22-107
“NF”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2981
“Occupational therapy”	R9-22-102
“Offeror”	R9-31-106
“Operating costs”	R9-22-107
“Outlier”	R9-31-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial care”	R9-31-112
“Peer group”	R9-22-107
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	A.R.S. § 36-2981
“Post stabilization services”	42 CFR 438.114

Arizona Administrative Register

Notices of Final Rulemaking

“Practitioner”	R9-22-102
“Pre-existing condition”	R9-31-105
“Prepaid capitated”	A.R.S. § 36-2981
“Prescription”	R9-22-102
“Primary care physician”	A.R.S. § 36-2981
“Primary care practitioner”	A.R.S. § 36-2981
“Primary care provider”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Program”	A.R.S. § 36-2981
“Proposal”	R9-31-106
“Prospective rates”	R9-22-107
“Provider”	A.R.S. § 36-2904 <u>A.R.S. § 36-2931</u>
“Prudent layperson standard”	42 U.S.C. 1396u-2
“PSP” or “ <u>Premium Sharing Program</u> ”	R9-31-103
“Psychiatrist”	R9-31-112
“Psychologist”	R9-31-112
“Psychosocial rehabilitation”	R9-31-112
“Qualified alien”	PL 104-193 <u>A.R.S. § 36-2903.03</u>
“Qualifying plan”	A.R.S. § 36-2981
“Quality management”	R9-22-105
“Radiology services”	R9-22-102
“RBHA”	R9-31-112
“Rebasing”	R9-22-107
“Redetermination”	R9-31-103
“Referral”	R9-22-101
“Registered nurse”	R9-31-112
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“RFP”	R9-31-106
“Respiratory therapy”	R9-22-102
“Respondent”	R9-22-108
“Scope of services”	R9-22-102
“SDAD”	R9-22-107
“Seriously ill”	R9-31-101
“Service location”	R9-22-101
“Service site”	R9-22-101
“SMI” or “ <u>Seriously mentally ill</u> ”	A.R.S. § 36-550
“Specialist”	R9-22-102
“Speech therapy”	R9-22-102
“Spouse”	R9-31-103
“SSI-MAO”	R9-31-103
“ <u>Stabilize</u> ”	<u>42 U.S.C. 1395dd</u>
“ <u>Standard of care</u> ”	<u>R9-22-101</u>
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
“Subcontractor”	R9-31-101
“Third-party”	R9-22-110
“Third-party liability”	R9-22-110
“Tier”	R9-22-107
“Tiered per diem”	R9-31-107
“Title XIX”	42 U.S.C. 1396
“Title XXI”	42 U.S.C. 1397aa
“TRBHA”	R9-31-116
“Tribal facility”	A.R.S. § 36-2981
“Utilization management”	R9-22-105

Arizona Administrative Register
Notices of Final Rulemaking

B. General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“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 who:

~~Has a provider agreement under A.R.S. § 36-2904,~~

~~Meets state and federal requirements, and~~

~~Is appropriately licensed or certified to provide AHCCCS covered services.~~

“Applicant” means a person who submits, or whose representative submits, a written, signed, and dated application for Title XXI benefits ~~which that~~ has not been approved or denied.

“Application” means an official request for Title XXI benefits made in accordance with Article 3.

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

“Inpatient hospital services” means medically necessary services that require an inpatient stay in an acute care hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member’s primary care provider.

“Native American” means Indian as specified in 42 CFR 36.1.

“Seriously ill” means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

Death,

Disability,

Disfigurement, or

Dysfunction.

“Subcontractor” means a person, agency, or organization ~~who that~~ enters into an agreement with a contractor or subcontractor.

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

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

B. ~~The Director has full operational authority to adopt rules or to use the appropriate rules adopted under A.R.S. § 36-2986. Scope of Services for fee for service members is under Article 16 of this Chapter.~~

C. A contractor or RBHA shall provide Behavioral behavioral health services shall be provided under 9 A.A.C. 31, Article 12 and Article 16.

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

~~1. Under, covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.~~

~~a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a member to a practitioner, and~~

~~b. The contractor may waive the referral requirements.~~

~~2. Services shall be rendered in accordance with state and federal laws and regulations, the Arizona Administrative Code, and AHCCCS contractual requirements.~~

~~3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered.~~

~~4. Services or items, if furnished gratuitously, are not covered and payment shall be denied.~~

~~5. Personal care items are not covered and payment shall be denied.~~

~~6. Services shall not be covered if provided to:~~

~~a. An inmate of a public institution under 42 CFR 435.1009,~~

~~b. A person who is a resident of an institution for the treatment of tuberculosis, or~~

~~c. A person who is in an institution for the treatment of mental diseases at the time of application.~~

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

1. Only medically necessary, cost effective, and federally and state reimbursable services are covered services;

2. The Administration or a contractor may waive the covered services referral requirements required by 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 shall 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;

Arizona Administrative Register
Notices of Final Rulemaking

5. A member may receive behavioral health evaluation services without a referral from a primary care provider. Behavioral health treatment services are provided only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
 6. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative 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 the Chief Medical Officer determines to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously;
 - c. Personal care items; and
 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. Services shall be provided by AHCCCS registered personnel or facilities, that meet state and federal requirements, and are appropriately licensed or certified to provide the services.~~
- ~~F. Payment for services or items requiring prior authorization may be denied if prior authorization by the contractor is not obtained. Emergency services do not require prior authorization.~~
1. ~~Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.~~
 2. ~~In addition to the requirements of 9 A.A.C. 31, Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.~~
- ~~E. The contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The provider shall submit documentation of diagnosis and treatment for reimbursement of services that require prior authorization.~~
- ~~F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the contractor.~~
- ~~G. As specified in Under A.R.S. § 36-2989, covered services rendered to a member shall be provided within the service area of the member's primary contractor except when: a member shall receive covered services outside the contractor service area only if one of the following apply:~~
1. ~~A primary care provider refers a member, out of the contractor's area for medical specialty care. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If a member is referred out of a contractor's service area to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for a member;~~
 2. ~~A covered service that is medically necessary for a member is not available within the contractor's service area;~~
 2. ~~There is a net savings in service delivery costs as a result of going outside the service area that does not require undue travel time or hardship for a member or the member's family;~~
 3. ~~A net savings in service delivery costs can be documented without requiring 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 contractor's service area; or~~
 4. ~~A member is placed in an NF located out of the contractor's service area; and~~
 5. ~~The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.~~
- ~~H. When If a member is traveling or temporarily residing out of the member's contractor service area, of the member's contractor, 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 these rules this Chapter and in contract.~~
- ~~J. If a member requests the provision of a service that is not covered by a contractor or not authorized by a contractor, the service may be rendered to a member by an AHCCCS registered service provider under the following conditions:~~
1. ~~A document that lists the requested services and the itemized cost of each is prepared by the contractor and provided to the member; and~~
 2. ~~The signature of the member is obtained in advance of service provision indicating that the services have been explained to the member and that the member accepts responsibility for payment.~~

Arizona Administrative Register
Notices of Final Rulemaking

- J.** If a member requests the provision of a service that is not covered or not authorized by a contractor, an AHCCCS-registered service provider may render the service and request reimbursement from the member if:
1. The provider prepares, and provides the member with, a document that lists the requested services and the estimated cost of each service; and
 2. The member signs a document before the provision of services indicating that the member understands the services and accepts the responsibility for payment.
- ~~**K.** If a member is referred out of a contractor's service area to receive an authorized medically necessary service a contractor shall also provide all other medically necessary covered services for a member during that time.~~
- ~~**L.**~~**K.** The restrictions, limitations, and exclusions in this Article shall do not apply to contractors when electing to a contractor when if the contractor elects to provide noncovered services:
1. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation. 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. ~~Nonecovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XXI services. A contractor shall pay 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

Inpatient services provided in a general hospital shall be covered by contractors or noncontracting providers and shall include: 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. ~~Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and~~ 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. ~~Labor, delivery and recovery rooms, and birthing centers;~~
 - b. ~~Surgery and recovery rooms;~~
 - e.a. Laboratory services;
 - d.b. Radiological and medical imaging services;
 - e.c. Anesthesiology services;
 - f.d. Rehabilitation services;
 - g.e. Pharmaceutical services and prescribed prescription drugs;
 - h.f. Respiratory therapy;
 - i.g. Blood and blood derivatives; and
 - j.h. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
 - k. ~~Maternity services; and~~
 - l. ~~Nursery and related services.~~

R9-31-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Attending Physician, Practitioner, and Primary Care Provider Services

- ~~**A.** Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. § 36-2981. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:~~
- A.** A primary care provider shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examinations examination and assessments assessment,
 2. Evaluations and diagnostic workups Evaluation and diagnostic workup,
 3. Medically necessary treatment,
 4. Prescriptions for medications medication and medically necessary supplies and or equipment,
 5. Referrals Referral to specialists a specialist or other health care professionals professional when if medically necessary as specified in A.R.S. § 36-2989,
 6. Patient education,
 7. Home visits when determined if medically necessary,

Arizona Administrative Register
Notices of Final Rulemaking

8. Covered immunizations, and
9. Covered preventive health services.
- B.** As specified in A.R.S. § 36-2989, a ~~2nd~~ second opinion procedure may be required to determine coverage for surgeries ~~surgery~~. Under this procedure, documentation must be provided by at least 2 ~~two~~ physicians as to the need for the proposed surgery for the member.
- C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
 1. Specialty care and other services provided to a member upon referral from a primary care provider ~~shall be~~ are limited to the services or conditions for which the referral is made, or for which authorization is given; ~~unless referral is waived by the contractor.~~ by the contractor;
 2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor 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:~~
 2. A member's physical examination is not a covered service if the physical examination is to obtain one or more of the following:
 - a. Qualification for insurance,
 - b. Pre-employment physical evaluation,
 - c. Qualification for sports or physical exercise activities,
 - d. Pilot's examination (FAA Federal Aviation Administration),
 - e. Disability certification ~~for establishing~~ to establish any kind of periodic payments,
 - f. Evaluation ~~for establishing~~ 3rd to establish third-party liabilities, or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
 3. The following services ~~shall be~~ are excluded from Title XXI AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and ~~sex change operations~~ gender reassignment surgery;
 - b. ~~Abortion~~ Pregnancy termination counseling services;
 - c. ~~Abortions~~ A pregnancy termination, unless authorized under federal law;
 - d. ~~Services or items~~ A service or item furnished solely for cosmetic purposes; ~~and~~
 - e. ~~Hysterectomies~~ A hysterectomy, unless determined to be medically necessary; ~~and~~
 - f. Licensed midwife services for prenatal care and home birth.

R9-31-207. Dental Services

Medically necessary dental services ~~shall be~~ are provided for children under age 19 ~~as specified in~~ under A.R.S. § 36-2989 ~~and~~ R9-22-213.

R9-31-208. Laboratory, Radiology, and Medical Imaging Services

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

1. Prescribed for members by a primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the contractor;
2. Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and
3. Provided by a 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 the provider's license or certification.

An AHCCCS-registered provider shall provide laboratory, radiology, and medical imaging services for children under age 19, under A.R.S. § 36-2989 and R9-22-208.

R9-31-209. Pharmaceutical Services

- A.** Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.
- B.** The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.
- C.** As specified in A.R.S. § 36-2989, pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider, unless referral is waived by the contractor or its designee.
- D.** The following limitations shall apply to pharmaceutical services:
 1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
 2. A prescription in excess of a 30 day supply or a 100 unit dose is not covered unless:
 - a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100 day supply or 100 unit dose, whichever is more.

Arizona Administrative Register
Notices of Final Rulemaking

- b. ~~The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.~~
 - e. ~~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 100 days or 100-unit dose, whichever is more.~~
 - 3. ~~A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.~~
 - 4. ~~A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.~~
 - 5. ~~Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.~~
 - E. ~~A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~
- Pharmaceutical services are provided for children under age 19 under R9-22-209.

R9-31-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices

- A. ~~As specified in A.R.S. § 36-2989, medical supplies, durable equipment DME, and orthotic and prosthetic devices shall be~~ are covered services if provided in compliance with requirements of this Chapter and:
 - 1. ~~Prescribed for a member by the member's primary care provider, practitioner, or dentist; or if prescribed by a physician or practitioner upon referral from the primary care provider, referral is waived by the contractor.~~
 - 2. ~~Provided in compliance with requirements of this Chapter Prescribed by a specialist upon referral from the primary care provider, practitioner, or dentist; and~~
 - 3. Authorized by the contractor or the contractor's designee.
- B. ~~Medical Covered medical supplies include are consumable items covered under Medicare items that are disposable and are essential to a member's health, that are provided to a member.~~
- C. ~~Medical equipment includes Covered DME is any durable item, appliance, or piece of equipment that is; designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.~~
 - 1. Designed for a medical purpose,
 - 2. To withstand wear,
 - 3. Generally reusable by others, and
 - 4. Purchased or rented for a member.
- D. ~~Prosthetic Covered prosthetic and orthotic devices include are only those items that are essential for the habilitation or rehabilitation of a member.~~
- E. ~~The following limitations apply on coverage include:~~
 - 1. ~~If medical equipment cannot be obtained from alternative resources at no cost, the medical equipment shall be DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment DME shall does not exceed the cost of the equipment DME if purchased;:~~
 - 2. ~~Reasonable repair or adjustment of purchased medical equipment shall be DME is covered if necessary to make the equipment DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit;:~~
 - 3. ~~Changes A change in, or additions addition to, an original order for medical equipment shall be DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for members a member, and shall be the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for medical equipment DME shall be made after a claim for services has been is submitted to a member's contractor, without prior written notification of the change or addition;:~~
 - 4. ~~Rental Reimbursement for rental fees shall terminate:~~
 - a. ~~No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the medical equipment DME;~~
 - b. ~~When If the member is no longer eligible for Title XXI AHCCCS services; or~~
 - c. ~~When If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Director Administration.~~
 - 5. ~~Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be are not covered unless needed to treat a medical condition and; provided in accordance with a prescription.~~
 - a. Prescribed by:
 - i. The member's primary care provider or practitioner, or
 - ii. A specialist upon referral from the primary care provider or practitioner; and
 - b. Authorized as required by the contractor or its designee;
 - 6. ~~First aid supplies shall not be are not covered unless they are provided in accordance with a prescription.~~
- F. ~~Liability and ownership.~~
 - 1. ~~Purchased durable medical equipment DME provided to a member but which that is no longer needed may be disposed of in accordance with each contractor's policy.~~

2. If customized ~~durable medical equipment~~ DME is purchased by the contractor for a member, the ~~equipment will~~ DME shall remain with the member during times of transition, or upon loss of eligibility.
 - a. For purposes of this Section, customized ~~durable medical equipment~~ DME refers to ~~equipment~~ DME that has been altered or built to specifications unique to a member's medical needs and ~~which that~~, most likely, cannot be used or reused to meet the needs of another individual.
 - b. ~~Customized equipment obtained fraudulently by a member shall be returned for disposal to the member's contractor. A member shall return customized DME obtained fraudulently to the Administration or the contractor.~~

R9-31-215. Other Medical Professional Services

~~A. The following medical professional services provided to a member by a contractor shall be covered services when provided are covered services if a member receives these services in an inpatient, outpatient, or office setting within limitations specified below as follows:~~

1. Dialysis;
2. Family planning services as specified in A.R.S. § 36-2989 including medications, supplies, devices, and surgical procedures ~~provided to delay or prevent pregnancy. Family planning services are limited to:~~ The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications.
 - b. Supplies.
 - c. Devices, and
 - d. Surgical procedures.
3. ~~Certified nurse midwife services provided by a certified nurse practitioner in midwifery;~~
3. Family planning services are limited to:
 - a. Contraceptive counseling, ~~medications~~ 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;
- 4-5. ~~Podiatry services when if~~ Podiatry services when if ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
- 5-6. ~~Respiratory therapy;~~
- 6-7. ~~Ambulatory and outpatient surgery facilities services;~~
- 7-8. ~~Home health services in A.R.S. § 36-2989;~~
- 8-9. ~~Private or special duty nursing services when if~~ Private or special duty nursing services when if medically necessary and prior authorized;
- 9-10. ~~Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy, and audiology within limitations in provided under this Article;~~
- 10-11. ~~Total parenteral nutrition services, (which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract);~~
- 11-12. ~~Chemotherapy Inpatient chemotherapy; and~~
13. Outpatient chemotherapy; and
- 12-14. Hospice care under R9-22-213.

~~B. The following shall be excluded as Title XXI covered services:~~

1. ~~Abortion counseling;~~
2. ~~Services or items furnished solely for cosmetic purposes;~~
3. ~~Chiropractic services, and~~
4. ~~Licensed midwife service for prenatal care and home births.~~

R9-31-216. Nursing Facility Services NF, Alternative HCBS Setting, or HCBS

A. Services provided in a NF, including room and board, alternative HCBS setting as defined in R9-28-101, or HCBS as defined in R9-28-101 services shall be ~~are~~ covered for a maximum of 90 days per contract year ~~if the medical condition of a member is such that, if NF services are not provided, hospitalization of the individual would result. if the member's medical condition would otherwise require hospitalization.~~

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

1. ~~Nursing services including but not limited to:~~
 - a. ~~Administration of~~ Administering medication,
 - b. Tube feedings,
 - c. Personal care services (assistance with bathing and grooming),
 - d. Routine testing of vital signs, and
 - e. Maintenance of ~~catheters~~ catheter.

Notices of Final Rulemaking

2. Basic patient care equipment and sickroom supplies, including, ~~but not limited to:~~
 - a. First aid supplies such as bandages, tape, ~~ointments~~ ointment, peroxide, alcohol, and ~~over the counter~~ over-the-counter remedies;
 - b. Bathing and grooming supplies;
 - c. Identification ~~devices~~ device;
 - d. Skin ~~lotions~~ lotion;
 - e. Medication ~~cups~~ cup;
 - f. Alcohol wipes, cotton balls, and cotton rolls;
 - g. Rubber gloves (~~non-sterile~~ non-sterile);
 - h. Laxatives;
 - i. ~~Beds~~ Bed and accessories;
 - j. ~~Thermometers~~ Thermometer;
 - k. Ice bags;
 - l. Rubber sheeting;
 - m. Passive restraints;
 - n. Glycerin swabs;
 - o. Facial tissue;
 - p. Enemas;
 - q. Heating ~~pads~~ pad; and
 - r. Diapers.
3. Dietary services including, ~~but not limited to~~, preparation and administration of special diets, and adaptive tools for eating;
4. ~~Any services that are included in an NF's room and board charge or services that are required of the NF to meet federal mandates, state licensure standards, or county certification requirements~~ 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. ~~Administrative-physician~~ Physician visits made solely for the purpose of meeting a state licensure ~~standards~~ standard or county certification ~~requirements~~ requirement;
6. Physical therapy; and
7. Assistive ~~devices and~~ device or non-customized ~~durable medical equipment~~ DME.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1603. Inpatient General Hospital Services

A. Inpatient services provided in a general hospital may include:

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. Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and Emergency behavioral services under 9 A.A.C. 31, Article 12;
2. ~~Ancillary~~ The following ancillary services as specified by the Director including:
 - a- ~~Labor, delivery and recovery rooms, and birthing centers~~;
 - b- ~~Surgery and recovery rooms~~;
 - e-~~a~~ Laboratory services;
 - ~~b~~ Radiological and medical imaging services;
 - e-~~c~~ Anesthesiology services;
 - f-~~d~~ Rehabilitation services;
 - g-~~e~~ Pharmaceutical services and ~~prescribed~~ prescription drugs;
 - h-~~f~~ Respiratory therapy;
 - i-~~g~~ Blood and blood derivatives; and
 - j-~~h~~ Central supply items, appliances, and equipment that are not ordinarily furnished to all patients ~~and~~ which are customarily reimbursed as ancillary services;
 - k- ~~Maternity services; and~~
 - l- ~~Nursery and related services.~~

Arizona Administrative Register
Notices of Final Rulemaking

- B.** The following limitations apply to ~~general~~ general inpatient general hospital services that are provided by a ~~fee-for-service~~ FFS provider and for which the Administration is financially responsible:
1. ~~The cost of an inpatient hospital accommodation for a member shall be incorporated into the rate paid for the level of care in subsection (A)(1).~~
 2. ~~Prior authorization shall be obtained from the Administration for a member referred out of the IHS or a Tribal Facility for the following inpatient hospital services provided to a member:~~
 - a. ~~Non-emergency and elective admission, prior to the scheduled admission;~~
 - b. ~~Elective surgery prior to the surgery;~~
 - c. ~~An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;~~
 - d. ~~Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; or~~
 - e. ~~A service or an item furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.~~
 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.

R9-31-1608. Pharmaceutical Services

- A.** Pharmaceutical services may be provided by the IHS, a Tribal Facility, or ~~under~~ upon referral from an IHS or a Tribal Facility provider.
- B.** As specified in A.R.S. § 36-2989, pharmaceutical services ~~shall be~~ 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 when if accessible pharmacies are closed.
 2. ~~A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:~~
 - a. ~~The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.~~
 - b. ~~The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.~~
 - c. ~~A member lives in an area not readily accessible to a pharmacy and the prescription is limited to 100 days or 100-unit dose, whichever is more.~~
 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 nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication. 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. ~~A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order. 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.~~
 5. ~~Approval by an authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by a dispensing pharmacist.~~
- D.** ~~The IHS or a Tribal Facility shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~

Arizona Administrative Register
Notices of Final Rulemaking

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.

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

A. ~~As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if prescribed for a member by the IHS or a Tribal Facility provider or if prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility provider unless referral is waived by a contractor.~~

A. Medical supplies, DME, and orthotic and prosthetic devices are covered services if provided in compliance with the requirements of this Chapter; and

1. Authorized by the Administration,
2. Prescribed by the IHS or Tribal Facility provider, or
3. Prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility unless the referral is waived by the Administration.

B. ~~Covered Medical~~ medical supplies include are consumable items covered under Medicare items that are disposable and are essential to a member's health, that are provided to a member.

C. ~~Medical equipment includes Covered DME is any durable item, an appliance, or a piece of equipment that is; designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.~~

1. Designed for a medical purpose,
2. To withstand wear,
3. Generally reusable by others, and
4. Purchased or rented for a member.

D. ~~Prosthetic Covered prosthetic~~ and orthotic devices include are only those items that are essential for the habilitation or rehabilitation of a member.

E. The following limitations on coverage apply:

1. ~~If medical equipment cannot be reasonably obtained from alternative resources at no cost, the medical equipment shall be DME is~~ furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment ~~DME shall does~~ not exceed the cost of the equipment ~~DME~~ if purchased.
2. Reasonable repair or adjustment of purchased ~~medical equipment shall be DME is~~ covered if necessary to make the equipment ~~DME~~ serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. ~~A changes change~~ in, or ~~additions addition~~ to, an original order for ~~medical equipment shall be DME is~~ covered if approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and ~~shall be the change or addition is~~ indicated clearly on the order and initialed by a vendor.
4. ~~Rental Reimbursement for rental~~ fees shall terminate:
 - a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that ~~a the~~ member no longer needs the ~~medical equipment DME,~~
 - b. ~~When a If~~ the member is no longer eligible for service through this program, or
 - c. ~~When a If~~ the member is no longer enrolled with the IHS with the exception of transitions of care as specified by the ~~Director Administration.~~
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming ~~shall not be are not~~ covered unless needed to treat a medical condition and; ~~provided in accordance with a prescription.~~
 - a. Prescribed by:
 - i. The member's attending physician or practitioner, or
 - ii. A specialist upon referral from an IHS or tribal facility provider, and
 - b. Authorized as required by the Administration.
6. First aid supplies ~~shall not be are not~~ covered unless they are provided according to a prescription.

F. Liability and ownership.

1. Purchased ~~durable medical equipment DME~~ provided to a member ~~but which that~~ is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.
2. If customized ~~durable medical equipment DME~~ is purchased for a member by the Administration, the equipment ~~will DME shall~~ remain with the member during times of transition, or upon loss of eligibility.
 - a. For purposes of this Section, customized ~~durable medical equipment DME~~ refers to equipment ~~DME~~ that has been altered or built to specifications unique to a member's medical needs and ~~which that,~~ most likely, cannot be used or reused to meet the needs of another individual.
 - b. ~~Customized A member shall return customized~~ equipment obtained fraudulently to the Administration. ~~by a member shall be returned for disposal to the Administration.~~

G. ~~A provider shall obtain prior authorization from the Administration before providing the following services to a member referred out of the IHS or a Tribal Facility:~~

1. ~~Consumable medical supplies exceeding \$50.00 per month.~~

Arizona Administrative Register
Notices of Final Rulemaking

2. ~~Durable medical equipment, prosthetic or orthotic devices for a member for all rentals if the cost to purchase the equipment or device exceeds \$200.00.~~

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

- 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; ~~and~~
 - d. Health education, including anticipatory guidance; and
 - e. Laboratory tests.
 2. Vision services ~~as specified in A.R.S. § 36-2989~~ including:
 - a. ~~Treatment for medical conditions of the eye, Diagnosis and treatment for defects in vision.~~
 - b. ~~1 eye examination per contract year, and Eye examinations for the provision of prescriptive lenses, and~~
 - c. ~~Provision of 1 pair of prescriptive lenses per contract year.~~
 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. ~~All providers~~ 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 ~~in accordance with the Administration's Periodicity Schedule 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;~~
 - a. ~~Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care;~~
 - b. ~~Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.~~
 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 ~~the following~~ additional conditions for a member ~~as stated in the Intergovernmental Agreement between the Administration and IHS:~~
1. ~~Provide information to a member and a member's parent or guardian concerning services, and~~
 2. ~~Notify a member and a member's parent or guardian regarding the initiation of screening and subsequent appointments according to the Administration's Periodicity Schedule.~~
- D. ~~A member with special health care needs may be referred to the Children's Rehabilitative Service program. 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

- A. The following medical professional services ~~provided to a member by the IHS or a Tribal Facility or for a member referred out of the IHS or a Tribal Facility shall be~~ are covered services as specified in A.R.S. § 36-2989 ~~when provided if a member receives these services in an inpatient, an outpatient, or an office setting within limitations specified below as follows:~~
1. Dialysis;
 2. ~~Family planning services including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:~~ 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~~ 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;
 - 3-4. ~~Midwife services provided by a certified nurse practitioner;~~
 - 4-5. ~~Podiatry services when if ordered by an IHS or a Tribal Facility provider;~~
 - 5-6. ~~Respiratory therapy;~~
 - 6-7. ~~Ambulatory and outpatient surgery facilities services;~~
 - 7-8. ~~Home health services;~~
 - 8-9. ~~Private or special duty nursing services when if medically necessary and prior authorized;~~

~~9-10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy, and audiology within limitations in provided under this Article;~~

~~10-11. Total parenteral nutrition services and which is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;~~

~~11. Chemotherapy;~~

~~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 ~~(10)~~ (12) for a member referred out of the IHS or a Tribal Facility service area.

R9-31-1614. Nursing Facility Services NF, Alternative HCBS Setting, or HCBS

A. Services provided in a NF services including room and board, alternative HCBS setting, or HCBS as defined in R9-28-101 shall be are covered for a maximum of 90 days per contract year if the medical condition of a member is such that, if NF services are not provided, hospitalization of an individual would result. if the member's medical condition would otherwise require hospitalization.

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

1. Nursing services including ~~but not limited to:~~

- a. Administration of medication,
- b. Tube ~~feedings~~ feeding,
- c. Personal care ~~services~~ service (assistance with bathing and grooming),
- d. Routine testing of vital signs, and
- e. Maintenance of ~~eatheters~~ catheter.

2. Basic patient care equipment and sickroom supplies, including, ~~but not limited to:~~

- a. First aid supplies such as bandages, tape, ~~ointments~~ ointment, peroxide, alcohol, and over the counter remedies;
- b. Bathing and grooming supplies;
- c. Identification ~~devices~~ device;
- d. Skin ~~lotions~~ lotion;
- e. Medication ~~cups~~ cup;
- f. Alcohol wipes, cotton balls, and cotton rolls;
- g. Rubber gloves (~~non-sterile~~ non-sterile);
- h. Laxatives;
- i. ~~Beds~~ Bed and accessories;
- j. ~~Thermometers~~ Thermometer;
- k. Ice ~~bags~~ bag;
- l. Rubber sheeting;
- m. Passive restraints;
- n. Glycerin swabs;
- o. Facial tissue;
- p. Enemas;
- q. Heating ~~pads~~ pad; and
- r. Diapers.

3. Dietary services including, ~~but not limited to, preparation and administration of~~ preparing and administering special diets, ~~and or~~ adaptive tools for eating;

4. Any services that are included in an NF's room and board charge or services that are required of an NF to meet federal mandates, state licensure standards, or county certification requirements; 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 ~~devices and device~~ or non-customized durable medical equipment DME.

C. ~~Each NF admission out of the IHS or a Tribal Facility's service area shall be prior authorized by the Administration. The Administration shall prior authorize each NF admission outside the IHS or a Tribal Facility's service area.~~

R9-31-1617. Prior Authorization

A provider and a ~~nonprovider~~ noncontracting provider shall request prior authorization from the Administration according to this Article. ~~The following inpatient hospital services provided to a member enrolled with the IHS out of the IHS or a Tribal Facility require prior authorization from the Administration:~~

1. ~~Nonemergency and elective admission, shall be authorized prior to admission;~~
2. ~~Elective surgery, excluding voluntary sterilization, shall be authorized prior to the surgery;~~

- ~~3. An emergency hospitalization that exceeds three days or an intensive care admission that exceeds one day;~~
- ~~4. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; and~~
- ~~5. Services or items furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.~~

NOTICE OF FINAL RULEMAKING

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 5. CORPORATION COMMISSION - TRANSPORTATION

PREAMBLE

- 1. Sections Affected**

	<u>Rulemaking Action</u>
R14-5-201	Amend
R14-5-202	Amend
R14-5-203	Amend
R14-5-204	Amend
R14-5-205	Amend
- 2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statutes: A.R.S. §§ 40-202, 40-203, 40-321, 40-441 and 40-442 et seq.
Constitutional authority: Arizona Constitution, Article XV
Implementing statute: Not applicable
- 3. The effective date of the rules:**

May 10, 2002
- 4. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Public Information: 6 A.A.R. 4209, November 3, 2000
Notice of Proposed Rulemaking: 6 A.A.R. 3635, September 22, 2000
Notice of Rulemaking Docket Opening: 6 A.A.R. 3117, August 18, 2000
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Jason D. Gellman, Attorney, Legal Division
Address: Corporation Commission
1200 W. Washington
Phoenix, AZ 85007
Telephone: (602) 542-3402
Fax: (602) 542-4870
- 6. An explanation of the rule, including the agency's reasons for initiating the rule:**
 1. Staff is proposing amendments to transportation rules R14-5-201, R14-5-202, R14-5-203, R14-5-204 and R14-5-205. The amendments will update the rules to incorporate the most recent amendments to the Code of Federal Regulations (CFR), Title 49, Parts 191, 192, 193, 195, 199 and Part 40.
 2. The amended rules will permit pipeline operators and property owners a means of resolving building encroachments over pipelines (R14-5-202(F)) and within three foot clearance of air intake (R14-5-202(I)).
 3. These proposed revisions also include a time-frame for removal of meter set assemblies and a format for filing required written reports of an incident at LNG facilities.
- 7. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**

None

Arizona Administrative Register
Notices of Final 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:

Small Business Subject to the Rules: These rules do not change the responsibilities of master meter operators already established in 1970 by the adoption by the Commission of the Code of Federal Regulations, Title 49, Parts 191 and 192.

The new rules will have no effect upon consumers or users of the gas service provided by regulated public utilities as they presently are required to be in compliance with all standards. This will benefit consumers, users, and the general public by maintaining a safe pipeline system. The proposed rules are the least costly method for obtaining compliance with the long standing minimum safety standards. The rules do not impose additional standards. There is no less intrusive method.

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

The Attorney General's Office reviewed these rules in accordance with A.R.S. § 41-1041. The Attorney General's Office proposed changes, which were approved the Arizona Corporation Commission. The proposed changes are non-substantive and are noted in bold-face type as follows:

R14-5-201 Definitions

As used in this Article:

11. "Sandy type soil" means sand no larger than "coarse" as defined by ASTM D-2487-83 (1983 Edition), incorporated by reference (and no future amendments) and on file with the Office of the Secretary of State **and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007.**

R14-5-202 Construction and Safety Standards

- B.** Subject to the definitional changes in R14-5-201 and the revisions noted in subsection (C), the Commission adopts, incorporates, and approves as its own 49 CFR 40, 191, 192 except I(2) and (3) of Appendix D to Part 192, 193, 195, except 195.1(b)(2) and (3), and 199, revised as of March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- E.** Operators of an intrastate pipeline transporting sour gas or oil are subject to industry standards addressing facilities handling hydrogen sulfide (H₂S). Standards adopted are:
 1. NACE Standard MR-0175-99 (1999 Revision); (and no future revisions), Standard Materials Requirements-Sulfide Stress Cracking Resistant Metallic Material for Oil Field Equipment, incorporated by reference and no future amendments. Copies are available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** NACE International, P.O. Box 218340, Houston, Texas 77218-8340 and on file with the Office of the Secretary of State.
 2. API RP55 (1995 Edition); (and no future amendments), API recommended practice for conducting oil and gas production operations involving hydrogen sulfide, incorporated by reference and no future amendments. Copies are available from **the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** CSSINFO, 310 Miller Avenue, Ann Arbor, Michigan, 48103 and on file with the Office of the Secretary of State.
- J.** Operators of an intrastate pipeline transporting LNG, natural gas, other gases or hazardous liquid will utilize a cathodic protection system designed to protect the metallic pipeline in its entirety, in accordance with 49 CFR 192, Subpart I, March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975 except I(2) and (3) of Appendix D to Part 192 shall not be utilized.
- K.** Operators of an intrastate pipeline transporting natural gas or other gas will not use solvent cement to join together plastic pipe manufactured from different materials unless the operator utilizes a joining procedure in accordance with the specifications of 49 CFR 192, Subpart F, ~~July 13, 1998~~ **March 1, 2000** (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- P.** Operators of an intrastate pipeline transporting natural gas or other gas pipeline system that construct an underground pipeline system using plastic pipe will install the pipe with sufficient slack to allow for thermal expansion and contraction. In addition, all plastic pipe shall be marked CD or CE as required by ASTM D2513-95c (1995c Edition and no future editions), incorporated by reference, on file with the Office of the Secretary of State, and

copies available from **the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** ASTM, 1916 Race Street, Philadelphia, Pennsylvania 19103-1187, for areas where the service temperature is above 100°F.

- Q. Operators of an intrastate pipeline system transporting hazardous liquid, natural gas or other gases shall qualify welding procedures and shall perform welding of steel pipelines in accordance with API Standard 1104. Each welder must be qualified in accordance with API Standard 1104, **49 CFR 192, appendix A**. The qualification of welders delineated in 49 CFR 192, appendix C may be used for low stress level pipe.
- R. Operators of an intrastate pipeline transporting natural gas or other gas pipeline system shall survey and grade all detected leakage by the following guide: ASME Guide for Gas Transmission and Distribution Pipeline System, Guide Material, Appendix G-11-1983 except 4.4(c) (1983 Revision and no future revisions), incorporated by reference and on file with the Office of the Secretary of State and copies available from **the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** ASME, United Engineering Center, 345 East 47th Street, New York, N. Y. 10017.

R14-5-203 Pipeline Incident Reports and Investigations

C. Require written incident report:

- 2. Written incident reports concerning natural gas or other gas pipeline systems will be in the following form:
 - a. RSPA F7100.1 - Distribution System: Incident Report, incorporated by reference and on file with the Office of the Secretary of State **and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007.**
 - b. RSPA F7100.2 - Transmission and Gathering System: Incident Report, incorporated by reference and on file with the Office of the Secretary of State **and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007.**
 - c. Written incident reports with respect to LNG facilities will be in an investigative form defining the incident and corrective action taken to prevent a recurrence.
- 3. Operators of an intrastate pipeline transporting hazardous liquid will make a written incident report on DOT Form 7000-1, incorporated by reference and on file with the Office of the Secretary of State, **and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007,** when there is a release of hazardous liquid which results in any of the following:

R14-5-204 Annual Reports

- A. Except for operators of an intrastate pipeline transporting LNG, hazardous liquid, all other intrastate pipeline operators will file with the Office of Pipeline Safety, not later than March 15 for the preceding calendar year, the following appropriate report(s):
 - 1. RSPA F7100.1-1 (November 1985 Edition and no future editions) - "Annual Report for Calendar Year 20___, Gas Distribution System" and "Instructions for Completing RSPA Form F7100.1-1, Annual Report for Calendar Year 20___, Gas Distribution System", incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation, Room 8417, 400 Seventh Street, S.W., Washington, D.C. 20590.
 - 2. RSPA F7100.2-1 (November 1985 Edition and no future editions) - "Annual Report for Calendar Year 20___, Gas Transmission and Gathering Systems" and "Instructions for Completing Form RSPA F7100.2-1, Annual Report for Calendar Year 20___, Gas Transmission and Gathering Systems", incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation, Room 8417, 400 Seventh Street, S.W., Washington, D.C. 20590.

R14-5-205 Master Meter System Operators

- B. Subject to the definitional changes in R14-5-201 and the revisions noted in subsection (C), the Commission adopts, incorporates, and approves as its own 49 CFR 191 and 192, ~~revised as of December 14, 1999~~ **March 1, 2000** (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- G. Operators of a master meter system will not use solvent cement to join together plastic pipe manufactured from different materials unless the operator utilizes a joining procedure in accordance with the specifications of 49 CFR 192, Subpart F, ~~July 13, 1998~~ **March 1, 2000** (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the **Commission Office of Pipeline**

Arizona Administrative Register
Notices of Final Rulemaking

Safety, 1200 West Washington, Phoenix, Arizona 85007 and the United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.

- J.** Operators of a master meter system that construct an underground pipeline using plastic pipe will install the pipe with sufficient slack to allow for thermal expansion and contraction. In addition, all plastic pipe shall be marked CD as required by ASTM D2513-95c (1995c Edition and no future editions), incorporated by reference, on file with the Office of the Secretary of State and copies available from **the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** ASTM, 1916 Race Street, Philadelphia, Pennsylvania 19103-1187, for areas where the service temperature is above 100°F.
- K.** Operators of a master meter gas system shall qualify welding procedures and shall perform welding of steel pipelines in accordance with API Standard 1104. Each welder must be qualified in accordance with API Standard 1104, **49 CFR 192, appendix A.**
- O.** Operators of a master meter system will perform leakage surveys at intervals not exceeding 15 months but at least once each calendar year and will survey and grade all detected leakage by the following guide -- ASME Guide for Gas Transmission and Distribution Pipeline System, Guide Material, Appendix G-11-1983 (1983 Revision and no future revisions), except 4.4(c), incorporated by reference, on file with the Office of the Secretary of State, and copies available from **the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the** ASME, United Engineering Center, 345 East 47th Street, New York, New York 10017. (“Should” as referenced in the guide will be interpreted to mean “shall”.) Leak detection procedures shall be approved by the Office of Pipeline Safety.

The following is a brief explanation of the changes proposed by the Attorney General’s Office and approved by the Arizona Corporation Commission listed above:

The first proposed group of changes reflect the fact that copies of regulations, reports, manuals and other pipeline materials are available, whenever incorporated by reference, from the Commission Office of Pipeline Safety, 1200 West Washington Street, Phoenix, Arizona 85007 at A.A.C R14-5-201(11); A.A.C. R14-5-202(B), (E)(1) and (2), (J), (K), (P), (R); A.A.C. R14-5-203(C)(2)(a) and (b), (C)(3); A.A.C. R14-5-204(A)(1) and (2); and R14-5-205(B), (G), (J), and (O). The AAG’s Office believes that such a provision is necessary to conform with A.R.S. § 41-1028, which requires that any material, incorporated by a rule, be made available from the agency issuing the rule. While Staff believes that the rules as passed in Decision No. 63517 meet the requirements of A.R.S. § 41-1028, no problem exists in accommodating the AAG’s request. This change does not substantively change the Rules and would merely provide another location by which a copy of incorporated rules would be obtainable. Changes to A.A.C. R14-5-205(P) were made to make the language there consistent with the proposed changes here.

The second proposed group of changes involves replacing the date of “July 13, 1998” with “March 1, 2000” in A.A.C. R14-5-202(K) and A.A.C. R14-5-205(G), and replacing “December 14, 1999” with “March 1, 2000” in A.A.C. R14-5-205(B). The change would reflect the passage of the most recent federal rules on March 1, 2000. The federal rules adopted on March 1, 2000 are still in effect at present and incorporate the changes made to the respective portions of the federal rules on July 13, 1998 and December 14, 1999. The AAG’s Offices’ changes here would not substantively change the Commission’s rules and would reflect the most recent review of the federal rules.

The third proposed group of changes adds the citation, 49 CFR 192, appendix A, after API Standard 1104 under both A.A.C. R14-5-202(Q) and A.A.C. R14-5-202(K). Adding this citation is giving a reference to where the API Standard 1104 is available in the federal regulations.

Additional changes made subsequent to the notice of proposed rulemaking and final rulemaking by the Commission are as follows:

R14-5-201(5)

Before:

5. “Intrastate pipeline” means all pipeline facilities referenced in A.R.S. 40.441, included in the definition of “pipeline system” that are used to transport natural gas, Liquefied Natural Gas (“LNG”), other gas or hazardous liquids within Arizona, that are not used to transport gas or hazardous liquids in interstate or foreign commerce. This includes, without limitation, any equipment, facility, building or other property used or intended for use in transporting gas, LNG or hazardous liquids.

After:

5. “Intrastate pipeline” means all pipeline facilities referenced in A.R.S. 40.441, included in the definition of “pipeline system” that are used by public service corporations to transport natural gas, Liquefied Natural Gas (“LNG”), other gas or hazardous liquids within Arizona, that are not used to transport gas or hazardous liquids in interstate or foreign commerce. This includes, without limitation, any equipment, facility, building or other property used or intended for use in transporting gas, LNG or hazardous liquids.

Arizona Administrative Register
Notices of Final Rulemaking

R14-5-201(9)

Before:

9. "Pipeline system" means all parts of those physical facilities ~~that are used by public service corporations~~ through which natural gas, liquefied natural gas ("LNG"), other gases or hazardous liquids move in transportation including, but not limited to, pipes, compressor units, metering stations, regulator stations, delivery stations, holders and fabricated assemblies.

After:

9. "Pipeline system" means all parts of those physical facilities that are used by public service corporations through which natural gas, liquefied natural gas ("LNG"), other gases or hazardous liquids move in transportation including, but not limited to, pipes, compressor units, metering stations, regulator stations, delivery stations, holders and fabricated assemblies.

R14-5-202(H)

Before:

- H. Operators of an intrastate pipeline transporting natural gas or other gas ~~pipeline system~~, that have regulators, meters, or regulation meter sets that have been out of service for 36 months will abandon those lines and cap all ends. This abandonment shall not exceed 6 months beyond the 36 months out service status.

After:

- H. Operators of an intrastate pipeline transporting natural gas or other gas ~~pipeline system~~, that have regulators, meters, or regulation meter sets that have been out of service for 36 months will abandon those lines and cap all ends. The operators steps to accomplish the abandonment shall not exceed 6 months beyond the 36 months out service status.

R14-5-203(B)(1)(e)

Before:

- e. Permanent or temporary discontinuance of gas service to a master meter system or when assisting with the isolation of any portion of a gas master meter system.

After:

- e. Permanent or temporary discontinuance of gas service to a master meter system or when assisting with the isolation of any portion of a gas master meter system due to a failure of a leak test.

R14-5-205(A)

Before:

- A. Applicability. This rule applies to the construction, reconstruction, repair, emergency procedures, operation and maintenance of all master meter systems, ~~as a condition of receiving service from public service corporations.~~ Noncompliance with this rule by operators of a master meter system shall constitute grounds for termination of service, by the public service corporation when informed in writing by the Office of Pipeline Safety. In case of an emergency, the Office of Pipeline Safety may give the public service corporation oral instructions to terminate service, with written confirmation to be furnished within 24 hours.

After:

- A. Applicability. This rule applies to the construction, reconstruction, repair, emergency procedures, operation and maintenance of all master meter systems, as a condition of receiving service from public service corporations. Noncompliance with this rule by operators of a master meter system shall constitute grounds for termination of service, by the public service corporation when informed in writing by the Office of Pipeline Safety. In case of an emergency, the Office of Pipeline Safety may give the public service corporation oral instructions to terminate service, with written confirmation to be furnished within 24 hours.

11. A summary of the principal comments and the agency response to them:

R14-5-201

Issue: In its original proposed amendments to the Rules as published in the September 22, 2000 Arizona Administrative Register, Staff proposed to add references to liquefied natural gas to the definitions. Staff also proposed the deletion of references to "public service corporations."

On October 19 and 26, 2000, ASARCO and AFFC, respectively, filed comments expressing concern that the Commission's proposed deletion of "public service corporations" would in essence, expand the jurisdiction of the Commission in violation of the Arizona Constitution.

ASARCO and AFFC also voiced their objection to the deletion of "public service corporations" from R14-5-201 at the Public Comment hearing on November 2, 2000.

Arizona Administrative Register
Notices of Final Rulemaking

At the Public Comment hearing, and in comments filed on October 31, 2000, Staff agreed not to delete any references to “public service corporations” from R14-5-201.

Analysis: In its October 31, 2000 comments, Staff indicated that its deletion of references to “public service corporations” was inadvertent.

The proposed amendments will also update the Rules to incorporate the most recent amendments to the Code of Federal Regulations.

Resolution: The Rules shall retain all references to “public service corporations” as they currently state.

R14-5-202

Issue: The proposed amendments update the rules to incorporate the most recent amendments to the Code of Federal Regulations.

Analysis: The proposed amendments incorporate the 1999 revision of NACE Standard MR0175, to replace the 1980 revision and the 1995 Edition of RP55 to replace the 1981 Edition. The proposed amendments also permit the pipeline operator and the property owner a means of resolving building encroachments over a pipeline and establish a time-frame for removal of meter set assemblies that have been out of service for a period of 36 months. The proposed amendments also permit the pipeline operator and the property owner a means of resolving encroachments within the required three (3) foot clearance between an electrical source, opening into a building or an air intake into a building, and a gas regulator that might release gas in its operations.

No parties opposed the proposed amendments.

Resolution: Staff’s proposed amendments to the Rule should be adopted.

R14-5-203

Issue: The proposed amendments will require written incident reports regarding liquefied natural gas to be in an investigative form defining the incident and the action taken to prevent the incident from reoccurring.

Analysis: The proposed amendments establish a format for filing required written reports of an incident at liquefied natural gas facilities.

SWG also filed comments seeking to add a condition to the requirement of incident reports filed by telephone. SWG seeks to add language that limits telephone reports due to a discontinuance of gas service to a master meter system or when assisting with the isolation of any portion of a gas meter system “due to a failure of a leak test.”

Staff agreed to the language proposed by SWG.

Resolution: Staff’s proposed amendments should be adopted and SWG’s proposed changes were incorporated into the final rules.

R14-5-204

Issue: Staff’s proposed amendments will update the dates and addresses listed in the Rule.

Analysis: The proposed amendments are logical and practical. No parties objected to Staff’s proposed amendments.

Resolution: Staff’s proposed amendments to the Rule should be adopted.

R14-5-205

Issue: Staff’s proposed amendments add references to public service corporations and update the rules by changing the dates of the revision of Federal rules.

Analysis: The proposed amendments are logical and practical. No parties objected to Staff’s proposed amendments.

Resolution: Staff’s proposed amendments to the Rule should be adopted.

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

None

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

Title 49, Code of Federal Regulations (CFR), Parts 40, 191, 192, except I(2) of Appendix D to Part 192, 193, 195 (except 195.1(b)(2) and (3)) and 199. These regulations cover the minimum safety standards for construction and operation of gas and hazardous liquid pipelines. These regulations may be found at the Arizona Corporation Commission, Executive Secretaries Office and Utilities Division, Pipeline Safety Section, 1200 West Washington Street, Phoenix, Arizona 85007. These regulations are incorporated by reference in the amended rules at: R14-5-202 (B), (C), (E)(1), (E)(2), (J), (K), (P), (Q), (R), R14-5-203(C)(2), (C)(3), (C)(5), R14-5-204 (A)(1), (A)(2), and R14-5-205 (B), (G), (J), (K), (O), and (P).

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

No

15. The full text of the rules follows:

**TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND
ASSOCIATIONS; SECURITIES REGULATION**

CHAPTER 5. CORPORATION COMMISSION - TRANSPORTATION

ARTICLE 2. PIPELINE SAFETY

Section

- R14-5-201. Definitions
- R14-5-202. Construction and Safety Standards
- R14-5-203. Pipeline Incident Reports and Investigations
- R14-5-204. Annual Reports
- R14-5-205. Master Meter System Operators

ARTICLE 2. PIPELINE SAFETY

R14-5-201. Definitions

As used in this Article:

1. "Abandon" means disconnecting the pipeline from all sources and supplies of gas, or hazardous liquids, purging the gas or hazardous liquids ~~within from~~ the pipeline being disconnected and capping all ends.
2. "Building" means any structure intended for supporting or sheltering any occupancy.
3. "Business District" means an area where the public congregate for economic, industrial, religious, education, health or recreational purposes and 2 or more buildings used for these purposes are located within 100 yards of each other.
4. "Commission" means the Arizona Corporation Commission.
5. "Intrastate pipeline" means all pipeline facilities ~~referenced in A.R.S. 40.441~~, included in the definition of "pipeline system" that are used by public service corporations to transport natural gas, Liquefied Natural Gas ("LNG"), other gas or hazardous liquids within Arizona, that are not used to transport gas or hazardous liquids in interstate or foreign commerce. This includes, without limitation, any equipment, facility, building or other property used or intended for use in transporting gas, LNG or hazardous liquids.
6. "Master meter system" means physical facilities for distributing gas within a definable area where the operator purchases metered gas from a public service corporation to provide gas service to 2 or more buildings other than at a single family residence.
7. "Operator" means a person that owns or operates a pipeline system or master meter system.
8. "Person" means any individual, firm, joint venture, partnership, corporation, association, cooperative association, joint stock association, trustee, receiver, assignee, personal representative, the state or any political subdivision thereof.
9. "Pipeline system" means all parts of those physical facilities that are used by public service corporations through which natural gas, ~~liquefied natural gas ("LNG")~~, other gases or hazardous liquids move in transportation including, but not limited to, pipes, compressor units, metering stations, regulator stations, delivery stations, holders and fabricated assemblies.
10. "Office of Pipeline Safety" means the Pipeline Safety personnel for the Commission.
11. "Sandy type soil" means sand no larger than "coarse" as defined by ASTM D-2487-83 (1983 Edition), incorporated ~~herein~~ by reference (and no future amendments) and on file with the Office of the Secretary of State and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007.
12. "State" means the state of Arizona and all lands within its boundaries.
13. "Structure" means that which is built or constructed, an edifice or building of any kind or any piece of work artificially built or composed of parts joined together in some definite manner.
14. "Transport" or "transportation" of gas, LNG or hazardous liquids ~~is~~ means the gathering, transmission, distribution ~~and~~ or storage of gas, LNG or hazardous liquids by pipeline within the state.

Arizona Administrative Register
Notices of Final Rulemaking

R14-5-202. Construction and Safety Standards

- A. Applicability: This rule applies to the construction, reconstruction, repair, operation and maintenance of all intrastate natural gas, other gas, LNG and hazardous liquid pipeline systems, as described in A.R.S. 40-441.
- B. Subject to the definitional changes in R14-5-201 and the revisions noted in subsection (C), the Commission adopts, incorporates, and approves as its own 49 CFR 40, 191, 192 except I (2) and (3) of Appendix D to Part 192, 193, 195, except 195.1(b)(2) and (3), and 199, revised as of ~~November 4, 1998~~ March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- C. The above mentioned incorporated Parts of 49 CFR, except Parts 191, 193 Subpart A and 195 Subpart A and B, are revised as follows:
1. Substitute "Commission" where "~~Office of Pipeline Safety, Administrator of the~~ Research and Special Programs Administration" or "Office of Pipeline Safety" (OPS) appear.
 2. Substitute "Office of Pipeline Safety, Arizona Corporation Commission, at its office in Phoenix, Arizona" where addresses for the ~~Information Systems Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, Materials Transportation Bureau, U.S. Department of Transportation or Office of Chief Counsel~~ appear.
- D. Operators of an intrastate pipeline will file with the Commission an Operation and Maintenance Plan (O & M), including an emergency plan, 30 days prior to placing a pipeline system into operation. Any changes in existing plans will be filed within 30 days of the effective date of the change.
- E. Operators of an intrastate pipeline transporting sour gas or oil are subject to industry standards addressing facilities handling hydrogen sulfide (H₂S). Standards adopted are:
1. NACE ~~sStandard MR-01-75~~ MR-0175-99 (1980 1999 Revision); (and no future revisions), Standard mMaterials equipment Requirements-sSulfide sStress eCracking rResistant mMetallic mMaterial for oil field Oilfield eEquipment, incorporated by reference and no future amendments. Copies are available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007, the NACE International, P.O. Box 218340, Houston, Texas 77218-8340, and on file with the Office of the Secretary of State.
 2. API RP55 (~~1981~~ 1995 Edition); (and no future amendments), API recommended practice for conducting oil and gas production operations involving hydrogen sulfide, incorporated by reference and no future amendments. Copies are available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007, the CSS-INFO, 310 Miller Avenue, Ann Arbor, Michigan, 48103, and on file with the Office of the Secretary of State.
- F. Operators of an intrastate pipeline transporting LNG, hazardous liquid, natural gas or other gas will not construct any part of a hazardous liquid, LNG, natural gas or other gas pipeline system under a building. For building encroachments over a pipeline system, the operator ~~will discontinue service~~ may require the property owner to remove the building from over the pipeline or reimburse the operator the cost associated with relocating the pipeline system. The encroachment shall be resolved within 180 days of discovery, or the operator shall discontinue service to the pipeline system. When the encroachment cannot be resolved within the 180 days the operator will shall submit to the Office of Pipeline Safety within 90 days of discovery a written plan to resolve the encroachment. The Office of Pipeline Safety may then extend the 180 day requirement in order to allow the ratepayer and the operator to implement the written plan to resolve the encroachment.
- G. Operators of an intrastate pipeline transporting LNG, hazardous liquid, natural gas or other gas ~~pipeline system~~ will not construct any part of a pipeline system closer than 8 inches to any other underground structure. If the 8 inch clearance cannot be maintained from other underground structures, a sleeve, casing, or shielding shall be used.
- H. Operators of an intrastate pipeline transporting natural gas or other gas ~~pipeline system~~, that have regulators, meters, or regulation meter sets that have been out of service for 36 months will abandon those lines and cap all ends. The operator's steps to accomplish the abandonment shall not exceed 6 months beyond the 36 months out service status.
- I. Operators of an intrastate pipeline shall not install or operate a gas regulator that might release gas in its operation closer than 3 feet to a source of ignition, opening into a building, air intake into a building or to any electrical source not intrinsically safe. The three (3) foot clearance from a source of ignition will be measured from the vent or source of release (discharge port), not from the physical location of the meter set assembly. This subsection shall not be effective with respect to building permits which are issued and subdivisions which are platted prior to October 1, 2000. For encroachment within the required three foot clearance caused by an action of the property owner, occupant or a service provider, after the effective date of this rule the operator may require the property owner to resolve the encroachment or reimburse the operator the cost associated with relocating the pipeline system. The encroachment shall be resolved within 180 days of discovery or the operator shall discontinue service to the effected pipeline system. When the encroachment cannot be resolved within the 180 days the operator shall submit to the Office of Pipeline Safety within 90 days of discovery a written plan to resolve the encroachment. The Office of Pipeline Safety may then extend the 180 day requirement in order to allow the ratepayer and the operator to implement the written plan to resolve the encroachment.

- J. Operators of an intrastate pipeline ~~system~~ transporting LNG, natural gas, other gases or hazardous liquid will utilize a cathodic protection system designed to protect the metallic pipeline in its entirety, in accordance with 49 CFR 192, Subpart I, ~~November 4, 1998~~ March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975 except I(2) and (3) of Appendix D to Part 192 shall not be utilized.
- K. Operators of an intrastate pipeline transporting natural gas or other gas ~~pipeline system~~ will not use solvent cement to join together plastic pipe manufactured from different materials unless the operator utilizes a joining procedure in accordance with the specifications of 49 CFR 192, Subpart F, ~~November 4, 1998~~ March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- L. Operators of an intrastate pipeline transporting hazardous liquid, natural gas or other gas ~~pipeline system~~ will not install Acrylonitrile-Butadiene-Styrene (ABS) or aluminum pipe in their pipeline systems.
- M. Operators of an intrastate pipeline transporting hazardous liquid, natural gas or other gas ~~pipeline systems~~ will not install plastic pipe aboveground unless the plastic pipeline is protected by a metal casing, or equivalent, and approved by the Office of Pipeline Safety. Temporary aboveground plastic pipeline bypasses are permitted for up to sixty (60) days, provided that the plastic pipeline is protected and is under the direct supervision of the operator at all times.
- N. Operators of an intrastate pipeline transporting hazardous liquid, natural gas or other gas ~~pipeline system~~ that construct a pipeline system or any portion thereof using plastic pipe, will install, at a minimum, a 14-gauge coated or corrosion resistant, electrically conductive wire as a means of locating the pipe while it is underground. Tracer wire shall not be wrapped around the plastic pipe, tracer wire may be taped, or attached in some manner to the pipe provided that the adhesive or the attachment is not detrimental to the integrity of the pipe wall.
- O. Operators of an intrastate pipeline transporting natural gas or other gas pipeline system that construct an underground pipeline system using plastic pipe, will bury the installed pipe with a minimum of 6 inches of sandy type soil surrounding the pipe for bedding and shading, free of any rock or debris, unless otherwise protected and approved by the Office of Pipeline Safety.
- P. Operators of an intrastate pipeline transporting natural gas or other gas pipeline system that construct an underground pipeline system using plastic pipe will install the pipe with sufficient slack to allow for thermal expansion and contraction. In addition, all plastic pipe shall be marked CD or CE as required by ASTM D2513-95c (1995c Edition and no future editions), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the ASTM, 1916 Race Street, Philadelphia, Pennsylvania 19103-1187, for areas where the service temperature is above 100°F.
- Q. Operators of an intrastate pipeline system transporting hazardous liquid, natural gas or other gases shall qualify welding procedures and shall perform welding of steel pipelines in accordance with API Standard 1104. Each welder must be qualified in accordance with API Standard 1104-, 49 CFR 192, appendix A. The qualification of welders delineated in 49 CFR 192, appendix C may be used for low stress level pipe.
- R. Operators of an intrastate pipeline transporting natural gas or other gas pipeline system shall survey and grade all detected leakage by the following guide: ASME Guide for Gas Transmission and Distribution Pipeline System, Guide Material, Appendix G-11-1983 except 4.4(c) (1983 Revision and no future revisions), incorporated by reference and on file with the Office of the Secretary of State and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the ASME, United Engineering Center, 345 East 47th Street, New York, N. Y. 10017. ("Should" as referenced in the Guide will be interpreted to mean "shall"). Leakage survey records shall identify in some manner each pipeline surveyed. Records shall be maintained to demonstrate that the required leakage survey has been conducted.
- S. All repair work performed on an existing intrastate pipeline transporting LNG, hazardous liquids, natural gas or other gas pipeline system will comply with the provisions of this Article.
- T. The Commission may waive compliance with any of the aforementioned parts upon a finding that such a waiver is in the interest of public and pipeline safety.
- U. To ensure compliance with provisions of this rule the Commission or an authorized representative thereof may enter the premises of an operator of an intrastate pipeline to inspect and investigate the property, books, papers, business methods, and affairs that pertain to the pipeline system operation.
- V. All other Commission administrative rules are superseded to the extent they are in conflict with the pipeline safety provisions of this Article.

R14-5-203. Pipeline Incident Reports and Investigations

- A. Applicability. This rule applies to all intrastate pipeline systems.
- B. Required incident reports by telephone:
1. Operators of an intrastate pipeline transporting LNG, natural gas or other gas pipeline system will notify by telephone the Office of Pipeline Safety upon discovery of the occurrence of any of the following:

- a. The release of natural gas, other gas or liquefied natural gas (LNG) from a pipeline or LNG facility, when any of the following results:
 - i. Death or personal injury requiring hospitalization.
 - ii. An explosion or fire not intentionally set by the operator.
 - iii. Property damage, including the value of the gas lost, estimated in excess of \$5,000.
 - b. Emergency transmission pipeline shutdown.
 - c. News media inquiry.
 - d. Overpressure of a pipeline system where a pipeline operating at less than 12 PSIG exceeds MAOP by 50%, where a pipeline operating between 12 PSIG and 60 PSIG exceeds MAOP by 6 PSIG or where a pipeline operating over 60 PSIG exceeds MAOP plus 10%.
 - e. Permanent or temporary discontinuance of gas service to a master meter system or when assisting with the isolation of any portion of a gas master meter system due to a failure of a leak test.
 - f. Emergency shutdown of a LNG process or storage facility.
2. Operators of an intrastate pipeline transporting hazardous liquid will notify by telephone the Office of Pipeline Safety upon discovery of the occurrence of any of the following:
 - a. Death or personal injury requiring hospitalization.
 - b. An explosion or fire not intentionally set by the operator.
 - c. Property damage estimated in excess of \$5,000.
 - d. Pollution of any land, stream, river, lake, reservoir, or other body of water that violates applicable environmental quality, water quality standards, causes a discoloration of the surface of the water or adjoining shoreline, or deposits sludge or emulsion beneath the surface of the water or upon adjoining shorelines.
 - e. News media inquiry.
 3. Telephone incident reports will include the following information:
 - a. Name of the pipeline system operator,
 - b. Name of the reporting party,
 - c. Job title of the reporting party,
 - d. The reporting party's telephone number,
 - e. Location of the incident,
 - f. Time of the incident, and
 - g. Fatalities and injuries, if any.
- C. Require written incident report:
1. Operators of an intrastate pipeline transporting natural gas, LNG or other gases will file a written incident report when an incident occurs involving a natural gas or other gas pipeline that results in any of the following:
 - a. An explosion or fire not intentionally set by the operator.
 - b. Injury to a person that results in 1 or more of the following:
 - i. Death.
 - ii. Loss of consciousness.
 - iii. Need for medical treatment requiring hospitalization.
 - c. Property damage, including the value of the lost gas, estimated in excess of \$5,000.
 - d. Emergency transmission pipeline shutdown.
 - e. Overpressure of a pipeline system where a pipeline operating at less than 12 PSIG exceeds MAOP by 50%, where a pipeline operating between 12 PSIG and 60 PSIG exceeds MAOP by 6 PSIG or where a pipeline operating over 60 PSIG exceeds MAOP plus 10%.
 - f. Emergency shutdown of a LNG process or storage facility.
 2. Written incident reports concerning natural gas or other gas pipeline systems will be in the following form:
 - a. RSPA F7100.1 - Distribution System: Incident Report, incorporated by reference and on file with the Office of the Secretary of State and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007.
 - b. RSPA F7100.2 - Transmission and Gathering System: Incident Report, incorporated by reference and on file with the Office of the Secretary of State and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007.
 - c. Written incident reports with respect to LNG facilities will be in an investigative form defining the incident and corrective action taken to prevent a reoccurrence.
 3. Operators of an intrastate pipeline transporting hazardous liquid will make a written incident report on DOT Form 7000-1, incorporated by reference and on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix Arizona 85007, when there is a release of hazardous liquid which results in any of the following:
 - a. An explosion or fire not intentionally set by the operator.
 - b. Injury to a person that results in 1 or more of the following:

Arizona Administrative Register
Notices of Final Rulemaking

- i. Death.
 - ii. Loss of consciousness.
 - iii. Inability to leave the scene of the incident unassisted.
 - iv. Need for medical treatment.
 - v. Disability which interferes with a person's normal daily activities beyond the date of the incident.
 - c. The loss of 50 or more barrels of hazardous liquid or carbon dioxide.
 - d. The escape of more than 5 barrels a day of highly volatile liquids into the atmosphere.
 - e. Property damage estimated in excess of \$5,000.
 - f. News media inquiry.
4. Written incident reports as required in this Section will be filed with the Office of Pipeline Safety, within the time specified below:
 - a. Natural gas, LNG or other gas - within 20 days after detection.
 - b. Hazardous liquids - within 15 days after detection.
 5. The Operators shall also file a copy of all DOT required written incident reports with the Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation, Washington, DC 20590.
 6. Operators of a natural gas or other gas pipeline system will request a clearance from the Office of Pipeline Safety prior to turning on or reinstating service to a master meter operator.
- D. Investigations by the Commission:**
1. The Office of Pipeline Safety will investigate the cause of incidents resulting in death or serious injury.
 2. Pursuant to an investigation under this rule, the Commission, or an authorized agent thereof, may:
 - a. Inspect all plant and facilities of a pipeline system.
 - b. Inspect all other property, books, papers, business methods, and affairs of a pipeline system.
 - c. Make inquiries and interview persons having knowledge of facts surrounding an incident.
 - d. Attend, as an observer, hearings and formal investigations concerning pipeline system operators.
 - e. Schedule and conduct a public hearing into an incident.
 3. The Commission may issue subpoenas to compel the production of records and the taking of testimony.
 4. Incidents not reported in accordance with the provisions of this rule will be investigated by the Office of Pipeline Safety.
 5. Incidents referred to in incomplete or inaccurate reports will be investigated by the Office of Pipeline Safety.
 6. Late filed incident reports will be accompanied by a letter of explanation. Incidents referred to in late filed reports may be investigated by the Office of Pipeline Safety.

R14-5-204. Annual Reports

- A.** Except for operators of an intrastate pipeline transporting LNG, ~~or~~ hazardous liquid, all other intrastate pipeline operators will file with the Office of Pipeline Safety, not later than March 15, for the preceding calendar year, the following appropriate report(s):
1. RSPA F7100.1-1 (November 1985 Edition and no future editions) - "Annual Report for Calendar Year ~~1920~~ 1920, Gas Distribution System" and "Instructions for Completing RSPA Form F7100.1-1, Annual Report for Calendar Year ~~1920~~ 1920, Gas Distribution System", incorporated ~~herein~~ by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation, Room 8417, 400 Seventh Street, S.W., Washington, D.C. 20590.
 2. RSPA F7100.2-1 (November 1985 Edition and no future editions) - "Annual Report for Calendar Year ~~1920~~ 1920, Gas Transmission and Gathering Systems" and "Instructions for Completing Form RSPA F7100.2-1, Annual Report for Calendar Year ~~1920~~ 1920, Gas Transmission and Gathering Systems", incorporated ~~herein~~ by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation, Room 8417, 400 Seventh Street, S.W., Washington, D.C. 20590.
- B.** The operator will also file a copy of all required annual reports by March 15 to the Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation; 400 Seventh Street S.W., Washington, D.C. 20590-0001.

R14-5-205. Master Meter System Operators

- A.** Applicability. This rule applies to the construction, reconstruction, repair, emergency procedures, operation and maintenance of all master meter systems, as a condition of receiving service from public service corporations. Noncompliance with this rule by operators of a master meter system shall constitute grounds for termination of service, by the public service corporation when informed in writing by the Office of Pipeline Safety. In case of an emergency, the Office of Pipe-

Arizona Administrative Register
Notices of Final Rulemaking

line Safety may give the public service corporation oral instructions to terminate service, with written confirmation to be furnished within 24 hours.

- B.** Subject to the definitional changes in R14-5-201 and the revisions noted in subsection (C), the Commission adopts, incorporates, and approves as its own 49 CFR 191 and 192, ~~revised as of November 4, 1998~~ March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- C.** The above mentioned incorporated parts of 49 CFR, except Part 191, are revised as follows:
1. Substitute "Commission" where "~~Office of Pipeline Safety, Administrator of the Research and Special Programs Administration~~", or "Office of Pipeline Safety" (OPS) appear.
 2. Substitute Office of "Pipeline Safety, Arizona Corporation Commission, at its office in Phoenix, Arizona" where addresses for the Information Resources Manager, Office of Pipeline Safety, Research and Special Programs Administration, U.S. Department of Transportation ~~or Office of Chief Counsel~~ appear.
- D.** Operators of a master meter system will establish an Operation and Maintenance Plan (O & M) including an emergency plan. The plans must be maintained at the master meter system location.
- E.** Operators of a master meter system will not construct any part of a natural gas or other gas system under a building or permit a building to be placed over a pipeline. Within 180 days of discovery of a building being located over a pipeline, the operator shall remove the building from over the pipeline, relocate the pipeline or discontinue the service to the pipeline located under the building.
- F.** Operators of a master meter system will not install Acrylonitrile-Butadiene-Styrene (ABS) or aluminum pipe in their systems.
- G.** Operators of a master meter system will not use solvent cement to join together plastic pipe manufactured from different materials unless the operator utilizes a joining procedure in accordance with the specifications of 49 CFR 192, Subpart F, ~~August 14, 1995~~ March 1, 2000 (and no future amendments), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the United States Government Printing Office, P.O. Box 371975M, Pittsburgh, Pennsylvania 15250-7975.
- H.** Operators of a master meter system that construct a pipeline or any portion thereof using plastic pipe will install, at a minimum, a 14-gauge coated or corrosion resistant, electrically conductive wire as a means of locating the pipe while it is underground. Tracer wire shall not be wrapped around the plastic pipe, tracer wire may be taped, or attached in some manner to the pipe provided that the adhesive or the attachment is not detrimental to the integrity of the pipe wall.
- I.** Operators of a master meter system that construct an underground pipeline using plastic pipe, will bury the installed pipe with a minimum of 6 inches of sandy type soil surrounding the pipe for bedding and shading, free of any rock or debris, unless otherwise protected and approved by the Office of Pipeline Safety.
- J.** Operators of a master meter system that construct an underground pipeline using plastic pipe will install the pipe with sufficient slack to allow for thermal expansion and contraction. In addition, all plastic pipe shall be marked CD as required by ASTM D2513-95c (1995c Edition and no future editions), incorporated by reference, on file with the Office of the Secretary of State and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the ASTM, 1916 Race Street, Philadelphia, Pennsylvania 19103-1187, for areas where the service temperature is above 100°F.
- K.** Operators of a master meter gas system shall qualify welding procedures and shall perform welding of steel pipelines in accordance with API Standard 1104. Each welder must be qualified in accordance with API Standard 1104, 49 CFR 192, appendix A.
- L.** All repair work performed on existing master meter systems will comply with the provisions of this Article.
- M.** Operators of a master meter system will not construct any part of a natural gas or other gas system closer than 8 inches to any other underground structure.
- N.** Operators of a master meter system will file a Notice of Construction 30 days prior to commencement of the construction of any pipeline. The Notice will contain the following information:
1. The dates of construction,
 2. The size and type of pipe to be used,
 3. The location of construction, and
 4. The Maximum Allowable Operating Pressure (MAOP).
- O.** Operators of a master meter system will perform leakage surveys at intervals not exceeding 15 months but at least once each calendar year and will survey and grade all detected leakage by the following guide -- ASME Guide for Gas Transmission and Distribution Pipeline System, Guide Material, Appendix G-11-1983 (1983 Revision and no future revisions), except 4.4(c), incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Commission Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007 and the ASME, United Engineering Center, 345 East 47th Street, New York, New York 10017. ("Should" as referenced in the guide will be interpreted to mean "shall".) Leak detection procedures shall be approved by the Office of Pipeline Safety.
- P.** Operators of a master meter system will file an annual report with the Commission on Commission Form 1-90/15M (1990 Edition and no future editions), "Annual Report for Calendar Year 1920", Small Operators of Gas Distribution Sys-

tem," incorporated by reference, on file with the Office of the Secretary of State, and copies available from the Arizona Corporation Commission, Office of Pipeline Safety, 1200 West Washington, Phoenix, Arizona 85007. This report will be filed with the Office of Pipeline Safety not later than April 15 for the preceding calendar year.

- Q. The Commission may waive compliance with any of the aforementioned parts upon a finding that such a waiver is in the interest of public safety.
- R. To ensure compliance with provisions of this rule, the Commission or an authorized representative thereof, may enter the premises of an operator of a master meter system to inspect and investigate the property, books, papers, business methods, and affairs that pertain to the operation of the master meter system.
- S. All other Commission administrative rules are superseded to the extent they are in conflict with the pipeline safety provisions of this Article.

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 4. DEPARTMENT OF TRANSPORTATION

TITLE, REGISTRATION, AND DRIVER LICENSES

PREAMBLE

1. **Sections Affected:** R17-4-410
Rulemaking Action: New Section
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. § 28-366
Implementing statute: A.R.S. § 16-112
3. **The effective date of the rules:**
May 9, 2002
4. **A list of all previous notices appearing in the Register addressing the final rule:**
Notice of Rulemaking Docket Opening: 7 A.A.R. 5993, December 28, 2001
Notice of Proposed Rulemaking: 8 A.A.R. 284, January 18, 2002
Notice of Public Information: 8 A.A.R. 657, February 15, 2002
5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: George R. Pavia, Department Rules Supervisor
Address: Administrative Rules Unit
Department of Transportation, Mail Drop 507M
3737 N. 7th St., Suite 160
Phoenix, AZ 85014-5079
Telephone: (602) 712-8446
Fax: (602) 241-1624
E-mail: gpavia@dot.state.az.us

Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.dot.state.az.us/about/rules.

6. **An explanation of the rule, including the agency's reasons for initiating the rulemaking:**
Arizona Department of Transportation, Motor Vehicle Division makes this rule to implement the requirements of A.R.S. § 16-112 in cooperation with the Arizona Secretary of State's Office. This Section will provide for license application-linked easy voter registration. See also the Secretary of State's Notice of Proposed Rulemaking for Section R2-12-601 through R2-12-612 published at 7 A.A.R. 5530, December 21, 2001, as a counterpart to this ADOT-MVD Section.

7. **A reference to any study that the agency relied on its evaluation or justification for the rule, and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
None
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:**
There are no costs to businesses resulting from this rulemaking. Private consumers will potentially benefit minimally in saved time and possibly also in mailing costs if opting for hardcopy voter registration. The agency will incur minimal to moderate initial costs in existing employee compensation to provide specifications and oversight for the Service Arizona vendor, IBM, to enhance electronic systems to handle online voter registration and transfer of voter data to the Secretary of State's electronic system. IBM will enhance Service Arizona to include easy voter registration without additional cost to the agency. The internal costs to the agency associated with initiating electronic voter registration are necessary because the voting registration method fulfills specific requirements of A.R.S. § 16-112(B)(4). Hardcopy voting registration requires minimal agency employee handling costs as part of regular duties.
10. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
Minor non-substantial changes were made at request of Council staff.
11. **A summary of the principal comments and the agency response to them:**
The agency received no comments on this rulemaking.
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:**
None
14. **Was this rule previously adopted as an emergency rule?**
No
15. **The full text of the rules follows:**

TITLE 17. TRANSPORTATION

CHAPTER 4. DEPARTMENT OF TRANSPORTATION
TITLE, REGISTRATION, AND DRIVER LICENSES

ARTICLE 4. DRIVER LICENSES

Section

R17-4-410. ~~Recodified~~ License Application-linked Easy Voter Registration

ARTICLE 4. DRIVER LICENSES

R17-4-410. ~~Recodified~~ License Application-linked Easy Voter Registration

- A.** For purposes of this Section, "license" has the same meaning as "Driver's License" under A.R.S. § 16-111(2).
- B.** To register to vote in Arizona through the Arizona Department of Transportation, Motor Vehicle Division "MVD," as provided in A.R.S. § 16-112, a person who completes a transaction listed in subsection (C) shall complete and return to MVD:
1. A Secretary of State-approved hardcopy voter registration form for the county of the person's residence, or
 2. An Easy Voter Registration form on MVD's Service Arizona web site at: www.servicearizona.ihost.com; and
 3. An electronic verification of voter eligibility according to criteria prescribed under A.R.S. § 16-101.
- C.** Subsection (B)(2) applies to the following license transactions:
1. Initial licensee application;
 2. License renewal; or
 3. Licensee personal information update.
- D.** MVD shall transfer the voter registration forms and the data collected under this Section by:
1. Mailing the completed hardcopy forms to the appropriate county recorder; and
 2. Transmitting the data from completed Easy Voter Registration forms and licensee personal information updates to the Secretary of State as prescribed under R2-12-605 for further distribution to the appropriate county recorder.
- E.** MVD shall maintain confidential applicant information as required under A.R.S Title 16, Chapter 1.