

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 9. HEALTH SERVICES

CHAPTER 7. DEPARTMENT OF HEALTH SERVICES CHILDREN'S REHABILITATIVE SERVICES

[R08-305]

PREAMBLE

1. Sections Affected

Rulemaking Action

R9-7-101	Amend
R9-7-201	Amend
R9-7-202	Amend
R9-7-203	Amend
Article 3	Amend
R9-7-301	Amend
R9-7-302	Amend
R9-7-303	Repeal
R9-7-303	New Section
R9-7-304	Repeal
R9-7-305	Repeal
R9-7-306	Repeal
R9-7-306	Repeal
R9-7-307	Repeal
R9-7-307	Repeal
R9-7-308	Repeal
R9-7-308	Repeal
R9-7-401	Repeal
R9-7-402	Repeal
R9-7-403	Repeal
R9-7-404	Repeal
R9-7-404	Repeal
R9-7-404	Repeal
R9-7-405	Repeal
R9-7-405	Repeal
R9-7-405	Repeal
R9-7-406	Repeal
R9-7-406	Repeal
R9-7-407	Repeal
R9-7-407	Repeal
R9-7-408	Repeal
R9-7-408	Repeal
R9-7-408	Repeal
R9-7-409	Repeal
R9-7-409	Repeal
R9-7-409	Repeal
R9-7-410	Repeal
R9-7-410	Repeal
R9-7-411	Repeal

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R9-7-411	Amend
R9-7-412	Renumber
R9-7-412	Amend
R9-7-413	Renumber
R9-7-413	Amend
R9-7-414	Renumber
R9-7-414	Amend
R9-7-415	Renumber
R9-7-415	Amend
R9-7-416	Renumber
R9-7-416	Amend
R9-7-417	Renumber
R9-7-417	Amend
R9-7-418	Renumber
R9-7-418	Amend
R9-7-419	Renumber
R9-7-419	Amend
R9-7-420	Renumber
R9-7-420	Amend
R9-7-421	Renumber
R9-7-501	Repeal
R9-7-501	Renumber
R9-7-501	Amend
R9-7-502	Renumber
R9-7-503	Renumber
R9-7-503	Amend
R9-7-504	Renumber
R9-7-504	Amend
R9-7-505	Renumber
R9-7-505	Amend
R9-7-506	Renumber
Article 6	Repeal
R9-7-601	Repeal
R9-7-602	Renumber
R9-7-603	Renumber
R9-7-604	Renumber
R9-7-701	Amend

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

Authorizing statute: A.R.S. §§ 36-104(3), 36-132(A)(1), and 36-136(F)

Implementing statute: A.R.S. §§ 36-143, 36-261 through 36-265, 36-797.43, and 36-797.44

3. The effective date of the rules:

October 1, 2008

The Department is requesting an immediate effective date pursuant to A.R.S. § 41-1032. An immediate effective date will preserve the public health under A.R.S. § 41-1032(A)(1) and provide a benefit to the public under A.R.S. § 41-1032(A)(4), specifically for CRS applicants, members, and families, and a penalty is not associated with a violation of the rules. The Department determined that the CRS enrollment process was cumbersome to applicants and CRS providers and that the rules created barriers to services by limiting community-based services and physician choice. The Department is amending the rules to streamline the CRS enrollment process, allow more community-based services, and remove references to regional contractors. These changes will enhance access to CRS services for applicants, members, and families. In addition, the Department has awarded a new statewide provider contract, pursuant to A.R.S. § 36-261, that eliminates separate regional clinics and establishes a unified statewide network of physicians and health care institutions consistent with the rule changes. The new statewide provider contract is effective October 1, 2008.

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 718, February 29, 2008

Notice of Proposed Rulemaking: 14. A.A.R. 1188, April 18, 2008

Notice of Supplemental Proposed Rulemaking: 14 A.A.R. 2335, June 13, 2008

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

Name: Kathleen Phillips, Esq.
Rules Administrator and Administrative Counsel

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or

Name: Joan Agostinelli
Office Chief and CRS Administrator

Address: Department of Health Services
Division of Behavioral Health Services
Office for Children with Special Health Care Needs
150 N. 18th Ave., Suite 330
Phoenix, AZ 85007

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E-mail: agostij@azdhs.gov

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

The Arizona Department of Health Services (Department) administers the Children's Rehabilitative Services program (CRS) to provide covered medical services and support services to eligible individuals and their families. A.R.S. Title 36, Chapter 2, Article 3, Children's Rehabilitative Services was added by Laws 1975, Ch. 21 § 1, effective May 12, 1975.

A.R.S. § 36-261(A)(5) requires the Department to "Establish and administer a program of service for children who are crippled or who are suffering from conditions which lead to crippling." The Department has entered into intergovernmental agreements with the Department of Economic Security (DES) and the Arizona Health Care Cost Containment System (AHCCCS) to ensure a continuum of cost-effective care for children enrolled with more than one agency. The Department does not provide services directly to children, but instead contracts with a network of hospitals, health professionals, and related entities to serve as providers of covered medical and support services on the Department's behalf and under the Department's authority. The Department provides administration, coordination, and oversight functions for the CRS program and CRS providers.

A.R.S. § 36-261(A)(3) requires the Department to adopt rules and policies for the operation of the CRS program. The rules in 9 A.A.C. 7 were adopted by final rulemaking at 10 A.A.R. 691, and were effective February 3, 2004, except 9 A.A.C. 7, Article 7, which was adopted by final rulemaking at 10 A.A.R. 3001 and was effective July 13, 2004. Because the rules no longer reflect Department policy and practice, the Department is amending 9 A.A.C. 7. The proposed rules conform to current Department policy and practice, industry standards, and rulemaking format and style requirements of the Office of the Secretary of State.

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

None

8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules 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:

For the rulemaking identified in item 6, annual cost/revenue changes are designated as minimal when less than \$25,000, moderate from \$25,000 to \$250,000, and substantial when greater than \$250,000 in costs or revenues. Costs are listed as significant when meaningful or important but not readily subject to quantification. Figures cited from data provided by the AHCCCS claims database indicates services delivered to CRS/AHCCCS members and does not include services provided to state-0%-pay members or members with 100% payment responsibility. The Department believes costs and quantities for CRS/AHCCCS members can be generalized to the rest of the CRS member population proportionally.

Cost bearers include the Department, CRS contractors, CRS members, CRS applicants, and third-party health insurance providers. Beneficiaries include the Department, DES, AHCCCS, CRS contractors, CRS providers, CRS members, CRS applicants, and third-party health insurance providers.

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- **The Department**

The Department administers CRS. The Department provides covered medical services through its designees, the CRS contractors, and economic impact due to changes to the covered medical services in Article 4 may be experienced concurrently by the Department and its designees. Where the Department or designee incurs costs to provide covered medical services, some or all of the costs may be offset by reimbursement from AHCCCS, payment from third-party health insurance providers, payment from 100% self-funded members, assignment of court awards, assignment of other insurance benefits, or other third-party payment.
- **CRS contractors**

CRS contractors are the Department's designees and are identified as the health plans and hospital networks that furnish services to CRS members. Although the rules do not identify "CRS contractors" separately from "CRS providers," this EIS distinguishes these entities from one another so that the costs and benefits for each type of entity can be identified.
- **CRS members**

CRS members are identified aggregately and according to several subgroups, each of which could experience differing economic impact from this rulemaking. During fiscal year 2007 CRS had 23,156 enrolled members. Of that total, 17,419 were also enrolled in AHCCCS Title XIX and 1,406 were also enrolled in AHCCCS Title XXI, for a total of 18,825 members, approximately 81% of all CRS members, identified in this EIS as "CRS/AHCCCS members." There were 4,331 members not enrolled in an AHCCCS program. State appropriations funded services for 3,065 members, approximately 13% of all CRS members, who have a 0% payment responsibility. These members are identified in this EIS as "state-0%-pay members." The remaining 1,266 members, about 5% of all CRS members, have a 100% payment responsibility, and include 507 members who have health care insurance other than AHCCCS and 759 members who self-fund their services, identified in this EIS as "100%-pay-insured members" and "100%-pay-self-funded members," respectively. The Department also provides some services to adults under statute, but CRS services to adults are not affected by this rulemaking.
- **CRS applicants**

CRS applicants are identified as individuals who potentially or actually fulfill the eligibility requirements for CRS and who request enrollment by applying to CRS.
- **DES**

DES is required by A.R.S. Title 36, Chapter 29 to determine Title XIX eligibility for AHCCCS applicants. AHCCCS determines Title XXI eligibility for AHCCCS applicants.
- **AHCCCS**

For the purpose of this EIS, economic impact to AHCCCS is not inclusive of the AHCCCS health plans. CRS provides a CRS/AHCCCS member with services related to the member's qualifying medical condition, but CRS does not provide the member's primary care services or unrelated medical treatment. The CRS/AHCCCS member's AHCCCS health plan provides the member all services not related to the member's CRS condition or not provided by CRS. AHCCCS is a funding source for CRS and for the AHCCCS health plans, paying state-appropriated and federal-appropriated funding for services for CRS/AHCCCS members regardless of whether CRS or the AHCCCS health plans provide the services. Accordingly, though CRS will provide some services under the proposed rules that were previously provided by AHCCCS health plans, there is no direct economic impact to AHCCCS because the funding source is unchanged.
- **CRS providers**

CRS providers are identified in this EIS as individual health professionals or small businesses employed or contracted by CRS contractors to serve the CRS member population at the point-of-encounter. CRS contractors are considered CRS providers as well, but this EIS identifies those entities only as "CRS contractors" for clarity.
- **Third-party health insurance providers**

In practice, a third-party health insurance provider can be a public or private entity. One example of a public third-party health insurance provider would be AHCCCS. For the purpose of this EIS; however, third-party health insurance providers are identified primarily as the private businesses that are the payors for services provided by CRS providers to 100%-pay-insured members. Some CRS/AHCCCS members obtain third-party health insurance to pay for treatment beyond the AHCCCS benefit limits, and some state-0%-pay members obtain third-party health insurance to pay for treatment beyond the CRS covered services, but the economic impact to third-party health insurance providers in those cases would not be directly impacted by this rulemaking.

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Cost/Benefit Analysis Reference Table

Identification of Affected Groups	Identification of Effect (Description follows in cost/benefit analysis below)	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
A. Federal, State, and Local Government Agencies			
The Department	Chapter 7: The cost to make and disseminate new rules and to assist stakeholders in implementation and use of new rules.	Minimal	None
	R9-7-101: Amending and updating definitions and terms to make the rules clearer and easier to use.	None	Significant
	R9-7-301: Amending enrollment requirements to no longer require the Department to provide an initial evaluation solely to determine an applicant's medical eligibility if the applicant's medical records are sufficient to confirm that the applicant has a CRS condition, freeing up Departmental and CRS contractor resources to provide other services.	None	Significant
	R9-7-301: Amending enrollment requirements to no longer cover the cost of initial evaluations for applicants with no third-party payor and who are not subsequently enrolled in CRS.	None	Minimal
	R9-7-302: Amending document submission requirements to no longer require the Department to collect citizenship, age, and residence documents from applicants already enrolled in AHCCCS, allowing the Department instead to verify citizenship, age, and residence through the applicant's existing AHCCCS membership.	None	Moderate
	R9-7-306: Amending income deduction allowances to clarify language that child-support payments are deductible in part for payments received, not deductible for payments paid or received.	None	Minimal-to-moderate
	R9-7-306: Amending income deduction allowances to allow medical expenses incurred within 12 months of application to be deducted, rather than allowing separate deductions for medical expenses paid within 12 months and medical expenses incurred at any time.	None	Minimal-to-moderate
	Article 4: Amending covered medical services limited to 24 sessions to instead be limited by the general requirements in R9-7-401.	Minimal	None
	Article 4: Amending covered medical services limited to 30 days in duration, except oxygen services, and services limited to a categorical schedule of service options to instead be limited by the general requirements in R9-7-401.	None	None
	R9-7-401: Amending covered medical services to allow secondary medical conditions to be provided in accordance with the general requirements in R9-7-401.	Significant	None

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Identification of Affected Groups	Identification of Effect (Description follows in cost/benefit analysis below)	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
	R9-7-402: Adding cochlear implant surgery to covered medical services.	Moderate	None
	R9-7-405: Amending covered medical services to allow home health services to be provided instead of inpatient hospitalization as well as before or after inpatient hospitalization.	None	Significant
	R9-7-406: Adding treatment of complications incurred during inpatient hospitalization for a member's CRS condition to covered medical services.	Significant	None
	R9-7-407: Adding motorized wheelchairs to covered services.	Minimal	None
	R9-7-407: Amending covered medical services to allow repairs of medical equipment, prosthetic devices, or orthotic devices CRS would otherwise replace, regardless of the provenance of the equipment or devices.	None	None-to-moderate
DES	R9-7-303: Allowing applicants who are not eligible for Title XIX health care insurance and who choose not to apply for state funding to decline to submit an AHCCCS application and instead enroll as members with 100% payment responsibility.	None	Significant
AHCCCS	R9-7-303: Allowing applicants who are not eligible for Title XXI health care insurance and who choose not to apply for state funding to decline to submit an AHCCCS application and instead enroll as members with 100% payment responsibility.	None	Significant
	R9-7-405: Amending covered medical services to allow home health services to be provided instead of inpatient hospitalization as well as before or after inpatient hospitalization.	None	Significant
	R9-7-407: Amending covered medical services to allow repairs of medical equipment, prosthetic devices, or orthotic devices CRS would otherwise replace, regardless of the provenance of the equipment or devices.	None	None-to-moderate
B. Privately Owned Businesses			
CRS contractors	R9-7-301: Amending enrollment requirements to no longer require the Department to provide an initial evaluation solely to determine an applicant's medical eligibility if medical records confirm that the applicant has a CRS condition, freeing Departmental and CRS contractor resources to provide other services.	None	Significant
	R9-7-301: Amending enrollment requirements to no longer cover the cost of initial evaluations for applicants with no third-party payor and who are not subsequently enrolled in CRS.	None	Minimal

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Identification of Affected Groups	Identification of Effect (Description follows in cost/benefit analysis below)	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
	R9-7-302: Amending document submission requirements to no longer require the Department to collect citizenship, age, and residence documents from applicants already enrolled in AHCCCS, allowing the Department instead to verify citizenship, age, and residence through the applicant's existing AHCCCS membership.	None	Moderate
	R9-7-303: Allowing applicants who are not eligible for Title XIX or Title XXI health care insurance and who choose not to apply for state funding to decline to submit an AHCCCS application and instead enroll as members with 100% payment responsibility.	None	Minimal
	R9-7-304: Amending the threshold by which the Department determines a member's payment responsibility from a fixed percentage of 200% to a variable percentage set annually based on appropriations and projected costs.	None	Substantial
	R9-7-306: Amending income deduction allowances to clarify language that child-support payments are deductible in part for payments received, not deductible for payments paid or received.	None	Minimal-to-moderate
	R9-7-306: Amending income deduction allowances to allow medical expenses incurred within 12 months of application to be deducted, rather than allowing separate deductions for medical expenses paid within 12 months and medical expenses incurred at any time.	None	Minimal-to-moderate
	Article 4: Amending covered medical services limited to 24 sessions to instead be limited by the general requirements in R9-7-401.	Minimal	None
	Article 4: Amending covered medical services limited to 30 days in duration, except oxygen services, and services limited to a categorical schedule of service options to instead be limited by the general requirements in R9-7-401.	None	None
	R9-7-401: Amending covered medical services to allow secondary medical conditions to be provided in accordance with the general requirements in R9-7-401.	Significant	None
	R9-7-402: Adding cochlear implant surgery to covered medical services.	Moderate	None
	R9-7-405: Amending covered medical services to allow home health services to be provided instead of inpatient hospitalization as well as before or after inpatient hospitalization.	None	Significant
	R9-7-406: Adding treatment of complications incurred during inpatient hospitalization for a member's CRS condition to covered medical services.	Significant	None

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Identification of Affected Groups	Identification of Effect (Description follows in cost/benefit analysis below)	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
	R9-7-407: Adding motorized wheelchairs to covered medical services.	Minimal	None
	R9-7-407: Amending covered medical services to allow repairs of medical equipment, prosthetic devices, or orthotic devices CRS would otherwise replace, regardless of the provenance of the equipment or devices.	None	None-to-moderate
	R9-7-408: Amending outpatient services to clarify requirements allowing CRS providers to treat members in non-clinic settings.	None	Significant
CRS providers	R9-7-402: Adding cochlear implant surgery to covered medical services.	None	Significant
	R9-7-407: Adding motorized wheelchairs to covered medical services.	None	Significant
	R9-7-408: Amending outpatient services to clarify requirements allowing CRS providers to treat members in non-clinic settings.	None	Significant
Third-party health insurance providers	Article 4: Amending covered medical services limited to 24 sessions to instead be limited by the general requirements in R9-7-401.	None	None
	Article 4: Amending covered medical services limited to 30 days in duration, except oxygen services, and services limited to a categorical schedule of service options to instead be limited by the general requirements in R9-7-401.	None	None
	R9-7-401: Amending covered medical services to allow secondary medical conditions to be provided in accordance with the general requirements in R9-7-401.	None	None
	R9-7-402: Adding cochlear implant surgery to covered medical services.	None	None
	R9-7-405: Amending covered medical services to allow home health services to be provided instead of inpatient hospitalization as well as before or after inpatient hospitalization.	None	Significant
	R9-7-406: Adding treatment of complications incurred during inpatient hospitalization for a member's CRS condition to covered medical services.	None	None
	R9-7-407: Adding motorized wheelchairs to covered medical services.	None	None
	R9-7-407: Amending covered medical services to allow repairs of medical equipment, prosthetic devices, or orthotic devices CRS would otherwise replace, regardless of the provenance of the equipment or devices.	None	None-to-moderate
C. Consumers			
CRS members	R9-7-306: Amending income deduction allowances to clarify language that child-support payments are deductible in part for payments received, not deductible for payments paid or received.	Minimal-to-moderate	None

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Identification of Affected Groups	Identification of Effect (Description follows in cost/benefit analysis below)	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
	R9-7-306: Amending income deduction allowances to allow medical expenses incurred within 12 months of application to be deducted, rather than separate deductions for medical expenses paid within 12 months and medical expenses incurred at any time.	Minimal-to-moderate	None
	Article 4: Amending covered medical services limited to 24 sessions to instead be limited by the general requirements in R9-7-401.	None	Significant
	Article 4: Amending covered medical services limited to 30 days in duration, except oxygen services, and services limited to a categorical schedule of service options to instead be limited by the general requirements in R9-7-401.	None	Significant
	R9-7-401: Amending covered medical services to allow secondary medical conditions to be provided in accordance with the general requirements in R9-7-401.	None	Significant
	R9-7-402: Adding cochlear implant surgery to covered medical services.	None	Significant
	R9-7-405: Amending covered medical services to allow home health services to be provided instead of inpatient hospitalization as well as before or after inpatient hospitalization.	None	Significant
	R9-7-406: Adding treatment of complications incurred during inpatient hospitalization for a member's CRS condition to covered medical services.	None	Significant
	R9-7-407: Adding motorized wheelchairs to covered medical services.	None	Significant
	R9-7-407: Amending covered medical services to allow repairs of medical equipment, prosthetic devices, or orthotic devices CRS would otherwise replace, regardless of the provenance of the equipment or devices.	None	None-to-moderate
	R9-7-408: Amending outpatient services to clarify requirements allowing CRS providers to treat members in non-clinic settings.	None	Significant
CRS applicants	R9-7-301: Amending enrollment requirements to no longer require the Department to provide an initial evaluation solely to determine an applicant's medical eligibility if the applicant's medical records are sufficient to confirm that the applicant has a CRS condition, freeing up Departmental and CRS contractor resources to provide other services.	None	Significant
	R9-7-301: Amending enrollment requirements so that the Department or CRS contractor no longer covers the cost of initial evaluations for applicants with no third-party payor who are not subsequently enrolled in CRS.	Minimal	None

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Identification of Affected Groups	Identification of Effect (Description follows in cost/benefit analysis below)	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
	R9-7-302: Amending document submission requirements to no longer require the Department to collect citizenship, age, and residence documents from applicants already enrolled in AHCCCS, allowing the Department instead to verify that information through AHCCCS.	None	Significant
	R9-7-303: Allowing applicants who are not eligible for Title XIX or Title XXI health care insurance and who choose not to apply for state funding to decline to submit an AHCCCS application and instead enroll as members with 100% payment responsibility.	None	Significant
	R9-7-304: Amending the threshold by which the Department determines a member's payment responsibility from a fixed percentage of 200% to a variable percentage set annually based on appropriations and projected costs.	Minimal-to-Substantial	None
	R9-7-306: Amending income deduction allowances to clarify language that child-support payments are deductible in part for payments received, not for payments paid.	Minimal-to-moderate	None
	R9-7-306: Amending income deduction allowances to allow medical expenses incurred within 12 months of application to be deducted, rather than separate deductions for medical expenses paid within 12 months and medical expenses incurred at any time.	Minimal-to-moderate	None

In general, public employment in agencies and political subdivisions will not be directly affected by this rulemaking. Private employment in businesses may be impacted by two changes in the proposed rules: CRS providing cochlear implants and motorized wheelchairs to members and CRS allowing CRS providers to provide services to members at non-CRS-clinic settings such as local hospital campuses and private physician's offices. The Department expects the impact of this rulemaking on private employment in businesses to be positive.

This rulemaking does not contain any changes that are expected to cause small businesses to incur additional costs. The Department has determined that the requirements in the rules are the least intrusive and least costly to small businesses while still complying with statutory requirements and meeting the needs of the public, private industry, regulated community, and government agencies. This rulemaking is not expected to directly impact state revenues.

The Department has determined that the requirements in the rules are the least intrusive and least costly manner to administer the CRS program while accomplishing the legislative objective underlying A.R.S. §§ 36-261 through 36-265 of serving the population of children with special health care needs and disabling medical conditions.

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

The Department did not make any substantive changes in the rules subsequent to the publication of the Notice of Supplemental Proposed Rulemaking on June 13, 2008 in the *Arizona Administrative Register* at 14 A.A.R. 2335.

The Department rephrased R9-7-303(A)(3) for clarity, changing the original text, "A statement that, based on the requirements for eligibility for Title XIX or Title XXI health care insurance provided to the individual by the Department, the individual is not eligible for Title XIX or Title XXI health care insurance," to, "A statement from the individual that the individual has reviewed the requirements provided by the Department for eligibility for Title XIX and Title XXI health care insurance, and the individual is not eligible for Title XIX or Title XXI health care insurance."

The Department added to R9-7-307(A) and R9-7-307(B)(1) the text "all or part of" to clarify what a member may be required to submit to the Department for redetermination.

The Department rephrased R9-7-307(F)(1) for clarity, changing the original text, "Informs the member that the member is no longer eligible for CRS" to:

- "1. Informs the member that the Department is terminating the member's enrollment according to R9-7-308 because:

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- a. The Department has determined that the member is no longer eligible for CRS, or
- b. The member did not comply with the requirements in R9-7-307 to verify that the member remains eligible for CRS”

The Department made a change to clarify the requirements in R9-7-307(I) by adding subsection (3), “The member is required to comply with the requirements in subsection (J) before the Department will provide a covered service to the member.”

The Department made the following changes for clarity in R9-7-307(J): The Department reversed the order of the subsections, and the Department added the phrase “if the member is not scheduled to receive a covered service within six months after the date of the notice” to the second subsection.

The Department rephrased R9-7-401(D) for clarity, changing the original text, “If the Department provides a member a medical service in another state, the Department shall not provide transportation or lodging for the member or the member’s family” to:

- “D. If the Department provides a member a medical service in another state, the Department shall not provide:
- 1. Lodging for the member or member’s family;
 - 2. Transportation for a member’s family; or
 - 3. Transportation for a member, except as provided in R9-7-406(B).”

Various grammatical and technical changes were also made at the suggestion of the Governor’s Regulatory Review Council (G.R.R.C.) staff. Not all of these minor changes are specifically referenced in items 10 or 11.

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

The Department did not receive any comments at the oral proceeding on May 21, 2008. The Department received comments at the supplemental oral proceeding on July 14, 2008. The Department received formal written comments from four stakeholders.

Comment	The Department’s Response
<p>One commenter stated that rule R9-7-301(E), which requires all applicants to complete the CRS application packet required in R9-7-302(A) and submit it within 90 days, could cause difficulty where cultural or literacy barriers impede applicants from completing the CRS application packet. The commenter asked the Department to ensure that outreach processes are in place to assist applicants in meeting this requirement.</p>	<p>The Department recognizes that there are cultural and literacy barriers and is required by rule R9-7-501(1) to provide assistance to applicants and their families to complete the CRS application packet. This and other advocacy services in Article 5 will continue to be provided by the Department through CRS providers.</p> <p>The application deadline of 30 days in the previous rules was extended to 90 days in this rulemaking. The Department received informal feedback on this issue during the drafting stage of this rulemaking. Applicants must sometimes acquire medical test results from other providers to submit to CRS, and feedback indicated that the 30-day deadline was insufficient in many instances. Conversely, feedback indicated that a deadline set too long may cause new CRS applications to languish unfinished for an indeterminate period of time. The Department determined that a 90-day deadline was reasonable.</p>
<p>One commenter stated that rule R9-7-307(A)(3), which requires members to provide a valid AHCCCS identification number or a copy of the member’s valid AHCCCS identification card when the Department performs a redetermination of the member’s payment responsibility, could cause difficulty because AHCCCS members do not always remember to bring their AHCCCS cards with them to appointments. The commenter suggested that the Department instead verify the member’s AHCCCS membership through the online database.</p>	<p>In practice, CRS providers typically verify the member’s AHCCCS membership through the online database or by contacting AHCCCS directly, as the commenter correctly indicates. There is no need for the provider to require the member to present an AHCCCS card in most instances. The Department has no plans to change that practice. If a CRS provider errs or otherwise fails to verify a member’s AHCCCS status, this rule ensures that the member will not lose access to CRS services without having had the notice and time-frame provided in rule to present evidence of valid AHCCCS membership and complete the requirements for redetermination.</p>

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Comment	The Department's Response
<p>One commenter asked in reference to Article 3 that the Department ensure that an accurate and efficient procedure is in place to notify AHCCCS health plans regarding members for whom the Department has provided and is awaiting a completed application, and for whom an application is considered withdrawn due to untimely receipt.</p>	<p>The rules establish eligibility and enrollment requirements for applicants and the Department. The commenter's request for third-party notification procedures is beyond the scope of this rulemaking.</p>
<p>One commenter expressed support for R9-7-401(C), stating that allowing members living near the Arizona borders to obtain services in neighboring states would reduce cost and inconvenience for members and families.</p>	<p>The Department agrees and appreciates the commenter's support.</p>
<p>One commenter cited the economic impact summary from the Notice of Proposed Rulemaking and expressed a concern that CRS members who do not see more than one provider at any visit during a year will be removed from the CRS clinic setting and will receive services only at private physician's offices, based on the changes to Article 4 that allow CRS to serve members in non-CRS-clinic settings. A second commenter stated the same concern in more general terms.</p>	<p>The changes to Article 4 that expand access to CRS services to include non-CRS-clinic settings do not replace the multi-specialty interdisciplinary clinic and are not meant to be an exclusive delivery setting for serving members with any CRS condition. The Department will not unilaterally exclude any member from the CRS clinic setting. Alternate settings, like those of hospital campuses or private physician's offices that may be closer to a member's home, may be offered for the convenience of members and their families. Even members who do not see more than one CRS provider are still expected to receive services in the CRS clinic setting at appropriate times based on those members' treatment plans.</p>
<p>Three commenters stated that the changes to Article 4 that allow CRS to serve members in non-CRS-clinic settings excluded members and families from the support services provided in the multi-specialty interdisciplinary clinic setting. These support services include the assistance of patient advocates, therapists, social workers, child-life specialists, and financial advisors, and are described in the rules in Article 5.</p>	<p>This rulemaking does not exclude members and families from support services by expanding access to CRS services to include non-CRS-clinic settings. Article 5 still requires CRS to provide support services. Support services are not solely tied to the multi-specialty interdisciplinary clinic.</p> <p>While the Department expects members, families, and physicians to benefit from access to CRS services in non-CRS-clinic settings, those settings do not replace the traditional CRS multi-specialty interdisciplinary clinic. Instead, they provide more options and greater access to CRS services to members and families.</p>
<p>Three commenters stated that the changes to Article 4 that allow CRS to serve members in non-CRS-clinic settings would impede providers of support services from delivering those services effectively. The commenters presented examples based on their own experiences of serving CRS members in the CRS clinic setting.</p>	<p>The Department does not agree. CRS will still provide support services according to Article 5, and the Department will continue to make those services available and accessible to CRS members and families. The delivery model for some services may change, and the Department understands that providers may experience a period of adjustment during any changes to the delivery model.</p>

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Comment	The Department's Response
<p>One commenter stated that the changes to Article 4 that allow CRS to serve members in non-CRS-clinic settings would transfer the burden of meeting the members' and families' needs for support services to other agencies that lack the body of accumulating and developing knowledge that exists in the CRS clinics. The commenter cited support services that coordinate care for CRS members, such as monitoring adherence to medical recommendations, assistance with communication with physicians, follow-up to interventions and referrals, ongoing monitoring of needs, and removal of barriers to treatment.</p>	<p>The Department does not agree. The rules still require CRS to provide support services according to Article 5, and the Department will continue to make those services available and accessible to CRS members and families.</p> <p>There is no language in this rulemaking indicating that CRS support services are being transferred to other agencies, and the Department has no plans to diminish the support services CRS provides.</p>
<p>One commenter stated in regard to R9-7-412 that the Department should be the primary payor, rather than the payor of last resort, for physical therapy or occupational therapy services provided to CRS members to treat CRS conditions. Specifically, subsection (1) does not require CRS to provide those services when the member is able to obtain those services through a source other than CRS or another health insurance provider.</p>	<p>The previous rules contain this provision at R9-7-413(A)(7). The change made by this rulemaking adds "or another health insurance provider" to clarify that these services do not overlap between CRS and other health insurance providers, such as AHCCCS health plans.</p> <p>In practice, unless a CRS provider determines that the member is receiving the service from another source, such as through school or through another governmental program such as DES-DDD, CRS provides the services under the requirements in R9-7-401.</p>
<p>One commenter stated that members and families who are at lower income levels often experience psychosocial issues connected to their lack of resources, and is concerned that the expansion of CRS services into non-CRS-clinic settings may impede social workers from addressing those issues.</p>	<p>The Department does not agree that the new rules impede social workers in this manner. To the contrary, in response to informal feedback during the early stages of this rulemaking, the Department agreed to revise R9-7-417, "Social Work Services," to enable social workers to provide services with fewer limitations.</p> <p>R9-7-417(1), as previously enacted in the 2004 rules at R9-7-418(1), requires that a psychosocial evaluation occur within a member's first three visits to a CRS clinic, but the Department interprets that rule as indicative of a time-frame, not a location. Accordingly, the new R9-7-417 states that a social worker shall provide an initial psychosocial evaluation "no later than the date of the member's third visit to a CRS provider." The social worker is free to conduct this evaluation at any location, even telephonically or through an audiovisual network connection if the member can be effectively evaluated in such a setting.</p> <p>R9-7-417(2) includes another amendment allowing a social worker to conduct psychosocial evaluations as needed throughout the member's enrollment, rather than conducting them only as indicated by the results of the member's initial psychosocial evaluation. The Department determined that the previous limitation could have been impeding social workers from serving CRS members effectively. Accordingly, this rulemaking removes that limitation.</p>

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Comment	The Department's Response
One commenter stated in regard to R9-7-418 that the Department should be the primary payor, rather than the payor of last resort, for speech/language pathology services provided to CRS members to treat CRS conditions. Specifically, subsection (1) does not require CRS to provide those services when the member is able to obtain those services through a source other than CRS or another health insurance provider.	The previous rules contain this provision at R9-7-419(A)(5). The change made by this rulemaking adds "or another health insurance provider" to clarify that these services do not overlap between CRS and other health insurance providers, such as AHCCCS health plans. In practice, unless a CRS provider determines that the member is receiving the service from another source, such as through school or through another governmental program such as DES-DDD, CRS provides the services under the requirements in R9-7-401.
Three commenters stated that this rulemaking provided increased benefits to CRS members and their families.	The Department's goals with this rulemaking included improving the accessibility and effectiveness of the CRS program to make it more beneficial for members and their families to participate. The Department appreciates the comments.
Three commenters expressed support for this rulemaking.	The Department appreciates the commenters' support.

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. Any material incorporated by reference and its location in the text:

None

14. Were these rules previously made as emergency rules?

These rules were not previously made as emergency rules.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 7. DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES**

ARTICLE 1. DEFINITIONS

Section
R9-7-101. Definitions

ARTICLE 2. ELIGIBILITY

Section
R9-7-201. Eligibility Requirements
R9-7-202. Medical Conditions
R9-7-203. Medical Ineligibility

**ARTICLE 3. REFERRAL; ENROLLMENT; APPLICATION;
FINANCIAL DETERMINATION; REDETERMINATION; TERMINATION**

Section
R9-7-301. Referral
R9-7-302. Enrollment
R9-7-303. ~~Initial Evaluation; Further Diagnostic Testing~~ Financial Screening
~~R9-7-304. Enrollment Application~~
R9-7-604. ~~R9-7-304. Member~~ Payment Responsibility
R9-7-602. ~~R9-7-305. Identification of Household Income Group~~
R9-7-603. ~~R9-7-306. Calculating Net Income~~
R9-7-305. ~~R9-7-307. Redetermination~~

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~~R9-7-306. R9-7-308. Termination of Enrollment~~

ARTICLE 4. COVERED MEDICAL SERVICES

Section

- R9-7-401. General Requirements
- ~~R9-7-402. Prior Authorization~~
- ~~R9-7-403. R9-7-402. Audiology Services~~
- ~~R9-7-404. R9-7-403. Dental and Orthodontia Services~~
- ~~R9-7-405. R9-7-404. Diagnostic Testing and Laboratory Services~~
- ~~R9-7-406. R9-7-405. Home Health Services~~
- ~~R9-7-407. R9-7-406. Inpatient Services~~
- ~~R9-7-408. R9-7-407. Medical Equipment~~
- ~~R9-7-409. R9-7-408. Nursing Services~~
- ~~R9-7-410. R9-7-409. Nutrition Services~~
- ~~R9-7-411. R9-7-410. Outpatient Services~~
- ~~R9-7-412. R9-7-411. Pharmaceutical Services~~
- ~~R9-7-413. R9-7-412. Physical Therapy and Occupational Therapy~~
- ~~R9-7-414. R9-7-413. Physician Services~~
- ~~R9-7-415. R9-7-414. Prosthetic and Orthotic Devices~~
- ~~R9-7-416. R9-7-415. Psychological Services~~
- ~~R9-7-417. R9-7-416. Psychiatric Services~~
- ~~R9-7-418. R9-7-417. Social Work Services~~
- ~~R9-7-419. R9-7-418. Speech/Language Pathology Services~~
- ~~R9-7-420. R9-7-419. Transplants~~
- ~~R9-7-421. R9-7-420. Vision Services~~
- R9-7-421. Renumbered

ARTICLE 5. COVERED SUPPORT SERVICES

Section

- ~~R9-7-501. General Requirements~~
- ~~R9-7-502. R9-7-501. Advocacy Services~~
- ~~R9-7-503. R9-7-502. Child Life Services~~
- ~~R9-7-504. R9-7-503. Education Coordination~~
- ~~R9-7-505. R9-7-504. Transition Services~~
- ~~R9-7-506. R9-7-505. Transportation Services~~
- R9-7-506. Renumbered

ARTICLE 6. ~~MEMBER PAYMENT~~ REPEALED

Section

- R9-7-601. General Requirements Repealed
- R9-7-602. Renumbered
- R9-7-603. Renumbered
- R9-7-604. Renumbered

ARTICLE 7. MEMBER APPEALS

Section

- R9-7-701. Member Appeals

ARTICLE 1. DEFINITIONS

R9-7-101. Definitions

In this Chapter, unless otherwise specified:

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
 - a. No change
 - b. No change

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7. "Application packet" means ~~an application form containing~~ the information in ~~R9-7-304(1)~~ R9-7-302(A) and additional documentation required by the Department to determine:
 - a. Whether an individual is eligible for CRS; and
 - b. If the individual is eligible for CRS, the payment responsibility of the individual or, if the individual is a minor, the individual's parent.
8. ~~"Behavioral health service" has the same meaning as in A.A.C. R9-20-101.~~
- 9-8. "Biologicals" means medicinal compounds prepared from living organisms and the product of living organisms such as serums, vaccines, antigens, and antitoxins.
10. ~~"Business day" means Monday, Tuesday, Wednesday, Thursday, or Friday excluding state and federal holidays.~~
- 11-9. No change
- 12-10. No change
- 13-11. No change
12. "Concurrent review" means an ongoing process conducted by the Department at the same time as the delivery of covered medical services to a member, such as during a member's inpatient treatment by a CRS provider, to determine whether the member is receiving medically necessary, effective, and cost-efficient treatment.
14. ~~"Co-payment" means the amount the Department requires a member to pay to a CRS provider for a medical service.~~
- 15-13. No change
- 16-14. "Crisis intervention service" means a behavioral health service as defined in A.A.C. R9-20-101 provided for a limited period of time to a member who is a danger to others as defined in A.A.C. R9-20-101 or a danger to self as defined in A.A.C. R9-20-101.
- 17-15. No change
- 18-16. "CRS clinic" means outpatient interdisciplinary evaluation and treatment provided by more than one ~~specialist~~ CRS provider at a specific location for a scheduled period of time.
- 19-17. "CRS condition" means any of the medical conditions in ~~Article 2 of this Chapter that make an individual medically eligible for CRS.~~ R9-7-202.
- 20-18. "CRS provider" means a person who is authorized by employment or written agreement with the Department ~~or a regional contractor~~ to provide covered medical services to a member or covered support services to a member or a member's family.
- 22-19. No change
- 24-20. No change
- 23-21. No change
- 24-22. "Department" means the Arizona Department of Health Services or its designee.
- 25-23. No change
24. "Designee" means a person acting on behalf of the Department under the authority of the Department.
26. ~~"DES" means the Arizona Department of Economic Security.~~
- 27-25. No change
- 28-26. No change
29. ~~"Eligibility interview" means an interaction between a Department representative and an applicant or member or, if the applicant or member is a minor, the applicant's or member's parent to review the documentation in R9-7-304(2) through (11).~~
- 30-27. No change
 - a. No change
 - b. No change
31. ~~"Emergency" means an immediate threat to the health or life of a member.~~
- 32-28. No change
- 33-29. No change
- 34-30. No change
35. ~~"Expiration date" means:~~
 - a. ~~The date on which a member's enrollment ends, or~~
 - b. ~~The date on which an individual's Title XIX or Title XXI health care insurance ends.~~
36. ~~"Facility" means a building or portion of a building.~~
- 37-31. No change
- 38-32. "Federal Poverty Level" means the current level of income set by the United States government, based on family size, ~~that is~~ used to determine whether an individual may receive ~~low income~~ income-based federal assistance.
- 39-33. No change
34. "Financial screening packet" means the information and documentation required by the Department to determine the payment responsibility of an individual or, if the individual is a minor, the individual's parent.
- 40-35. No change
- 41-36. "Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activ-

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- ity of daily living as determined by a ~~specialist~~ CRS provider.
- ~~42-37~~. No change
- ~~43-38~~. No change
- ~~44-39~~. No change
- ~~45-40~~. No change
- ~~46-41~~. No change
- ~~47-42~~. No change
- ~~48-43~~. No change
- ~~49-44~~. No change
- ~~50-45~~. No change
- ~~51-46~~. “Household income group” means all of the individuals whose income the Department includes when calculating an individual’s or member’s payment responsibility for covered services.
- ~~52-47~~. No change
- ~~53-48~~. No change
- ~~49~~. “Medical condition” means the state of an individual’s physical or mental health, including the individual’s illness, injury, or disease.
- ~~54-50~~. “Medical expenses” means charges incurred by an individual for:
- ~~a. medical~~ Medical equipment;
 - ~~b. medication~~ Medication or biologicals prescribed by a physician ~~or specialist~~, physician’s assistant, or registered nurse practitioner;
 - ~~c. dental~~ Dental services;
 - ~~d. treatment~~ Treatment by a ~~physician or specialist~~ health professional, as defined in A.R.S. § 32-3201, except a veterinarian;
 - ~~e. inpatient~~ Inpatient services;
 - ~~f. outpatient~~ Outpatient services; or
 - ~~g. health~~ Health care insurance premiums for the individual.
- ~~57-51~~. “Medical service” means evaluation or treatment of a member by a ~~physician or specialist who is a~~ CRS provider.
- ~~55-52~~. No change
- ~~56-53~~. No change
- ~~58-54~~. No change
- ~~59-55~~. No change
- ~~60-56~~. “Minor” means an individual who is:
- a. Under ~~the age of 18 years~~, 18 years of age and is not:
 - i. Married; or
 - ii. Emancipated, as specified in A.R.S. Title 12, Chapter 15;
 - b. Incompetent, as determined by a court of competent jurisdiction; or
 - c. No change
- ~~57~~. “Net income” means an individual’s gross income minus the deductions in R9-7-306(C).
- ~~61-58~~. No change
- ~~62-59~~. No change
- ~~63-60~~. “Occupational therapy” has the same meaning as in A.R.S. § ~~32-2001~~; 32-3401.
- ~~64-61~~. No change
- ~~65-62~~. “Outpatient services” means evaluating, monitoring, or treating an individual at a ~~facility~~, hospital, physician’s office, ~~regional clinic, or outreach clinic~~ or CRS clinic for less than 24 hours.
- ~~66~~. “Outreach clinic” means a ~~facility or a specific location in a facility designated by a regional contractor to provide covered medical services or covered support services in a setting other than a regional clinic~~.
- ~~67-63~~. No change
- ~~68-64~~. “Payment agreement” means a form containing a an individual’s or member’s signed, written promise to pay for covered medical services according to the terms on the form.
- ~~69-65~~. “Payment responsibility” means that portion of the cost for medical services that a an individual or member is required to pay and has agreed to pay according to a signed written agreement.
- ~~70-66~~. No change
- ~~71-67~~. “Pharmaceutical services” means medications and biologicals ordered by a physician, dentist, physician’s assistant, or registered nurse practitioner.
- ~~72-68~~. “Physical therapy” has the same meaning as in A.R.S. § ~~32-3401~~; 32-2001.
- ~~73-69~~. No change
- ~~74-70~~. No change
- a. No change
 - b. No change

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71. “Physician’s assistant” has the same meaning as in A.R.S. § 32-2501.
- ~~75-72.~~ “Prior authorization” means a written approval signed by ~~a regional contractor or the regional contractor’s designee~~ the Department or the Department’s designee before a covered service is provided to a member.
- ~~76-73.~~ No change
- ~~77-74.~~ No change
- ~~79-75.~~ No change
- ~~78-76.~~ No change
- ~~81-77.~~ No change
- ~~80-78.~~ No change
- ~~82-79.~~ No change
- ~~83-80.~~ “Qualified alien” has the same meaning as in A.R.S. § ~~36-2903.03(G)~~; 36-2903.03(I).
- ~~86-81.~~ “Redetermination” means a decision made by the Department regarding whether a:
- ~~Member continues to be eligible for CRS, or meets the requirements in R9-7-201, or~~
 - ~~Member’s payment responsibility is changed.~~
- ~~84-82.~~ No change
- ~~85-83.~~ “Referral source” means a person who refers an individual to CRS.
84. “Registered nurse practitioner” has the same meaning as in A.R.S. § 32-1601.
85. “Retrospective review” means the process conducted by the Department following the completion of the delivery of covered medical services to a member to determine if the member received medically necessary, effective, and cost-efficient treatment.
- ~~90-86.~~ No change
- ~~No change~~
 - ~~No change~~
 - ~~No change~~
 - ~~No change~~
- ~~87.~~ “Regional clinic” means a facility or specific location in a facility designated by a regional contractor:
- ~~To provide covered medical services and covered support services, and~~
 - ~~As the location for the regional contractor’s administrative office.~~
- ~~88.~~ “Regional contractor” means a person who has a written agreement with the Department to provide covered medical services and covered support services.
- ~~89.~~ “Regional medical director” means a physician employed by a regional contractor to make:
- ~~Medical determinations about members, and~~
 - ~~Prior authorizations for medical services provided to members.~~
- ~~91-87.~~ No change
- ~~93-88.~~ No change
- ~~92-89.~~ “Social worker” means an individual ~~certified~~ licensed under A.R.S. Title 32, Chapter 33, Article 5.
- ~~95-90.~~ No change
- ~~96-91.~~ No change
- ~~97-92.~~ “Title XIX” means the Federal Medicaid Program, 42 U.S.C. 1396 through 1396v, a health care insurance program administered jointly by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services and, in Arizona, by AHCCCS, through which ~~an eligible individuals receive individual receives~~ health care, that is administered jointly by the U.S. Department of Health and Human Services and, in Arizona, by AHCCCS ~~excluding provisions in the Federal Medicaid Program for an individual who is not a U.S. citizen or qualified alien.~~
- ~~98-93.~~ “Title XXI” means the State Children’s Health Insurance Program, 42 U.S.C. 1397aa through 1397jj, through which ~~an eligible children receive individual receives~~ health care insurance that is administered by AHCCCS, ~~excluding provisions in the State Children’s Health Insurance Program for an individual who is not a U.S. citizen or qualified alien.~~
- ~~94.~~ “Specialist” means:
- ~~A physician who is a CRS provider with professional education, knowledge, and skills related to a specific service or procedure, age category of patients, body system, or type of disease; or~~
 - ~~A CRS provider, other than a physician, who requires specific professional education, knowledge, and skills to deliver a medical service or support service.~~
- ~~99-94.~~ No change
- ~~100-95.~~ No change
- ~~101-96.~~ No change
97. “Utilization management” means the processes by which the Department determines medically necessary, effective, and cost-efficient covered medical services and treatment for a member, including:
- Prior authorization.
 - Concurrent review, and

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c. Retrospective review.

ARTICLE 2. ELIGIBILITY

R9-7-201. Eligibility Requirements

- A. An individual is eligible to enroll for CRS if the individual:
1. No change
 2. No change
 3. No change
 - a. No change
 - b. No change
 4. Is living in Arizona ~~and intends to continue living in Arizona.~~
- B. No change
1. No change
 2. No change
- C. No change
1. No change
 2. No change
 3. No change

R9-7-202. Medical Conditions

An individual is medically eligible for CRS, only if the individual has:

1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
2. One or more of the following endocrine system medical conditions:
 - a. Hypothyroidism;²
 - b. Hyperthyroidism;²
 - c. Adrenogenital syndrome;²
 - d. Addison's disease;²
 - e. Hypoparathyroidism;²
 - f. Hyperparathyroidism;²
 - g. Diabetes insipidus;²
 - h. Cystic fibrosis;² and
 - i. ~~For an individual who was a member before November 1, 1995, panhypopituitarism with a deficiency of growth hormone; and~~
 - j. Panhypopituitarism;
 - k. ~~For an individual who became a member or applies for enrollment after November 1, 1995, panhypopituitarism with a deficiency of growth hormone and two other pituitary hormones;~~
3. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
4. One or more of the following ear, nose, or throat medical conditions:
 - a. No change
 - b. No change

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- c. No change
- d. No change
- e. No change
- f. No change
- g. Craniofacial anomaly that requires treatment by more than one ~~specialist~~ CRS provider; and
- h. No change
- 5. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
 - m. No change
 - n. No change
 - o. No change
 - p. No change
 - q. No change
 - r. No change
 - s. No change
 - t. No change
 - u. No change
 - v. No change
 - w. No change
 - x. No change
 - y. No change
 - z. No change
 - aa. No change
 - bb. No change
 - cc. No change
 - dd. No change
 - ee. No change
 - ff. No change
 - gg. No change
 - i. No change
 - ii. No change
 - hh. No change
 - ii. No change
 - jj. No change
 - kk. No change
 - ll. No change
 - mm. No change
 - nn. No change
 - oo. No change
 - pp. No change
 - i. No change
 - ii. No change
 - qq. No change
 - rr. No change
- 6. No change
 - a. No change
 - b. No change
 - c. No change

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- d. No change
- e. No change
- f. No change
- g. No change
- h. No change
- i. No change
- j. No change
- k. No change
- l. No change
- 7. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
 - m. No change
 - n. No change
 - o. No change
 - p. No change
 - q. No change
 - r. No change
 - s. No change
 - t. No change
- 8. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
- 9. No change
 - a. No change
 - b. No change
- 10. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
- 11. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
- 12. No change
- 13. A medical condition, other than one of the conditions in R9-7-203, that, as determined by ~~a regional medical director:~~
the Department:
 - a. Requires specialized treatment similar to the type and quantity of treatment a medical condition in subsections

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- (1) through (12) requires,
- b. Is as likely to result in functional improvement with treatment as a medical condition listed in subsections (1) through (12), and
- c. Requires long-term follow-up of the type and quantity required for a medical condition listed in subsections (1) through (12).

R9-7-203. Medical Ineligibility

~~An individual who has one or more of the following medical conditions, but does not have one or more of the medical conditions in R9-7-202, is not medically eligible for CRS:~~

An individual who does not have one or more of the medical conditions in R9-7-202, and who has one or more of the following medical conditions, is not medically eligible for CRS:

- 1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
- 2. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
- 3. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
- 4. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
- 5. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - i. No change
 - ii. No change
 - h. No change
 - i. No change
- 6. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change

- e. No change
- f. No change
- g. No change
- h. No change
- 7. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
- 8. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
- 9. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
- 10. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
- 11. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - i. No change
 - ii. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
 - m. No change
 - n. No change
 - o. No change

**ARTICLE 3. REFERRAL; ENROLLMENT; APPLICATION;
FINANCIAL DETERMINATION; REDETERMINATION; TERMINATION**

R9-7-301. Referral

- A.** To refer an individual, a referral source shall submit to the Department a referral form containing:
1. The name, sex, home address, and home telephone number of the individual;
 2. If the individual is a minor, the name of a parent of the individual;
 3. If applicable, the work telephone number of the parent in subsection (A)(2);
 4. The name, address, and telephone number of the referral source;
 5. If the individual previously received covered medical services or covered support services, the year in which the individual received covered medical services or covered support services, and the regional contractor responsible for providing covered medical services or covered support services to the individual;
 6. Relationship of the referral source to the individual; and
 7. If known to the referral source, the individual's:
 - a. Birth date;
 - b. Diagnosis; and
 - c. Physician.
- B.** If an individual has Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the form in subsection (A) and:
1. Documentation from a physician who evaluated the individual, stating the individual's diagnosis made by the physician; and
 2. Diagnostic test results that support the individual's diagnosis made by the physician.
- C.** If an individual does not have Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the form in subsection (A) and:
1. If the individual has not been evaluated by a physician, the reason the referral source believes that the individual may be eligible for CRS; or
 2. If the individual has been evaluated by a physician:
 - a. Documentation from the physician who evaluated the individual, stating the individual's diagnosis made by the physician; and
 - b. If available, diagnostic test results that support the individual's diagnosis made by the physician.
- D.** Within 10 business days from the date of receipt of a referral:
1. If the Department determines that a individual may be eligible for CRS, the Department shall notify the referral source and provide the individual or, if the individual is a minor, the individual's parent:
 - a. An application form in R9-7-304(1) and a list of the documentation required in R9-7-304(2) through (11);
 - b. A written notice that the individual may be eligible for CRS and that:
 - i. After the Department receives the application form in R9-7-304(1) from the individual or, if the individual is a minor, the individual's parent, the individual is authorized to receive an initial evaluation to determine whether the individual is medically eligible for CRS;
 - ii. The individual or, if the individual is a minor, the individual's parent is required to participate in an eligibility interview before or during the individual's initial evaluation;
 - iii. The Department has scheduled an appointment for the individual's initial evaluation at a CRS clinic, the date of the individual's appointment, the address of the CRS clinic, and the procedure for rescheduling the appointment if the individual is unable to keep the scheduled appointment; and
 - iv. The individual is not authorized to receive covered medical services or covered support services other than the initial evaluation until the individual and, if the individual is a minor, the individual's parent comply with the application requirements in R9-7-302(B) and the Department determines that the individual meets the eligibility requirements in R9-7-201; and
 - c. Information about CRS, including:
 - i. An overview of CRS;
 - ii. Medical and non-medical eligibility requirements for CRS;
 - iii. The application requirements in R9-7-302(B), and
 - iv. Criteria for determining which individuals are part of a household income group;
 2. If the Department determines that the individual is not eligible for CRS, the Department shall:
 - a. Notify the referral source; and
 - b. Provide the individual or, if the individual is a minor, the individual's parent a written notice that:
 - i. Informs the individual or, if the individual is a minor, the individual's parent that the Department has determined the individual is not eligible for CRS; and
 - ii. Complies with A.R.S. § 41-1092.03; or
 3. If the Department determines the referral source did not submit the information and documentation required in subsection (A), the Department shall provide a written notice to the referral source that:

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- a. Identifies the missing documentation or information;
 - b. Requests the referral source to submit the missing information or documentation within 30 calendar days from the date of the notice; and
 - e. Informs the referral source that, if the Department does not receive the documentation or information within 30 calendar days from the date of the notice, the Department shall consider the referral withdrawn.
- E.** If the Department requests information or documents according to subsection (D)(3), and the Department:
- 1. Receives the requested documentation and information within 30 calendar days from the date of the notice in subsection (D)(3), the Department shall determine whether the individual may be eligible for CRS and notify the referral source and the individual or, if the individual is a minor, the individual's parent according to subsection (D)(1) or (D)(2) within 10 business days from the date of receipt of the requested documentation and information; or
 - 2. Does not receive the requested documentation and information within 30 calendar days from the date of notice in subsection (D)(3), the Department shall consider the referral withdrawn.
- F.** If the Department determines that an individual may be eligible for CRS, the Department shall schedule the date of an initial evaluation no more than 30 calendar days after the date of the determination.
- A.** To refer an individual, a referral source shall submit to the Department the following information:
- 1. The individual's:
 - a. Name;
 - b. Date of birth;
 - c. Home address; and
 - d. Contact information, such as a telephone number or e-mail address;
 - 2. If known to the referral source, the individual's Social Security number;
 - 3. If the individual is a minor, the name of a parent of the individual;
 - 4. If known to the referral source, whether the individual is:
 - a. A U.S. citizen, or
 - b. A qualified alien;
 - 5. The name, address, and telephone number of the referral source;
 - 6. The relationship of the referral source to the individual;
 - 7. If known to the referral source:
 - a. The individual's diagnosis, and
 - b. The name of the individual's physician; and
 - 8. If known to the referral source, whether the individual has:
 - a. Title XIX health care insurance,
 - b. Title XXI health care insurance, or
 - c. Other health care insurance.
- B.** If an individual has Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department:
- 1. The information in subsection (A);
 - 2. Documentation from a physician who evaluated the individual, stating the individual's diagnosis; and
 - 3. Diagnostic test results that support the individual's diagnosis.
- C.** If an individual does not have Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department:
- 1. The information in subsection (A);
 - 2. If the individual has not been evaluated by a physician, the reason the referral source believes that the individual may have a CRS condition; and
 - 3. If the individual has been evaluated by a physician:
 - a. Documentation from the physician who evaluated the individual, stating the individual's diagnosis; and
 - b. If available, diagnostic test results that support the individual's diagnosis.
- D.** The Department shall provide written notice of the Department's eligibility determination to a referral source and the referred individual within 14 days from the date of receipt of a referral.
- E.** If the Department determines that the individual has a CRS condition and may be eligible for CRS, the Department shall provide the individual or, if the individual is a minor, the individual's parent:
- 1. A written notice that the individual has a CRS condition and that:
 - a. The individual may be eligible for CRS;
 - b. The Department will not enroll the individual in CRS until the individual:
 - i. Completes and submits to the Department the application packet required in R9-7-302(A);
 - ii. Complies with the financial screening requirements in R9-7-303, if applicable; and
 - iii. Completes and submits to the Department the payment agreement described in R9-7-304(A); and
 - c. If the Department does not receive the documents in subsection (E)(1)(b) within 90 days from the date of the notice in subsection (E)(1), the Department shall consider the application withdrawn.
 - 2. Information about CRS, including:

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- a. An overview of CRS.
- b. The medical services and support services covered by CRS.
- c. The grievance and appeal process.
- d. The enrollment requirements in R9-7-301 and R9-7-302 and an explanation of the enrollment process.
- e. The financial screening requirements in R9-7-303 and an explanation of the financial screening process, and
- f. The percentage of the Federal Poverty Level established according to R9-7-304(C) by which the Department determines a member's payment responsibility and an explanation of the Department's process to determine a member's payment responsibility;
3. The application packet required in R9-7-302(A);
4. The financial screening packet described in R9-7-303; and
5. The payment agreement described in R9-7-304(A).
- F.** If the Department determines that the individual is not eligible for CRS, the Department shall provide the individual or, if the individual is a minor, the individual's parent a written notice that:
 1. Informs the individual or, if the individual is a minor, the individual's parent of the reason why the individual is not eligible for CRS; and
 2. Complies with A.R.S. § 41-1092.03.
- G.** If the Department determines the referral source did not submit the information and documentation required in subsections (A) through (C):
 1. The Department shall provide a written notice to the referral source and the referred individual that:
 - a. Identifies the missing information or documentation;
 - b. Requests the referral source or referred individual to submit the missing information or documentation within 90 days from the date of the notice; and
 - c. Informs the referral source and referred individual that, if the Department does not receive the information or documentation within 90 days from the date of the notice, the Department shall consider the referral withdrawn.
 2. If the Department receives the information or documentation requested in subsection (G)(1) within 90 days of the notice in that subsection, the Department shall, within 14 days from the date of receipt of the requested information or documentation, make an eligibility determination and provide notice according to this Section.
 3. If the Department does not receive the information or documentation requested in subsection (G)(1) within 90 days of the notice in that subsection, the Department shall consider the referral withdrawn.
- H.** If the Department determines that further diagnostic testing or an initial evaluation is necessary for the Department to determine whether the individual has a CRS condition, the Department shall provide the individual or, if the individual is a minor, the individual's parent:
 1. A written notice that:
 - a. Further diagnostic testing or an initial evaluation of the individual is necessary in order for the Department to determine whether the individual has a CRS condition; and
 - b. If applicable, includes the name and contact information for the person the individual can contact in order to schedule further diagnostic testing or an initial evaluation; and
 - c. Informs the individual or, if the individual is a minor, the individual's parent that, if the Department does not receive the results of further diagnostic testing within 90 days from the date of the notice, or the individual does not receive an initial evaluation within 90 days from the date of the notice, the Department shall consider the referral withdrawn;
 2. Information about CRS, including:
 - a. An overview of CRS.
 - b. The medical services and support services covered by CRS.
 - c. The grievance and appeal process.
 - d. The enrollment requirements in R9-7-301 and R9-7-302 and an explanation of the enrollment process.
 - e. The financial screening requirements in R9-7-303 and an explanation of the financial screening process, and
 - f. The percentage of the Federal Poverty Level established according to R9-7-304(C) by which the Department determines a member's payment responsibility and an explanation of the Department's process to determine a member's payment responsibility;
 3. The application packet required in R9-7-302(A);
 4. The financial screening packet described in R9-7-303; and
 5. The payment agreement described in R9-7-304(A).
- I.** If an individual receives the notice in subsection (H)(1) that further diagnostic testing is necessary, the individual shall:
 1. If the individual has Title XIX or Title XXI health care insurance, request that AHCCCS complete the diagnostic testing and send the results of the diagnostic testing to the Department;
 2. If the individual has other health care insurance that provides the diagnostic testing, request and complete the diagnostic testing and submit the results of the diagnostic testing to the Department; or
 3. If the individual does not have health care insurance or has health care insurance that does not provide the diagnostic

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testing:

- a. Complete and submit to the Department the payment agreement described in R9-7-304(A) before the individual receives the diagnostic testing; and
- b. Contact the person indicated in the notice in subsection (H)(1)(b) to schedule the diagnostic testing, if applicable.
- J.** If an individual receives the notice in subsection (H)(1) that an initial evaluation is necessary, the individual shall:
 - 1. Complete and submit to the Department the payment agreement described in R9-7-304(A) before the individual receives an initial evaluation; and
 - 2. Contact the person indicated in the notice in subsection (H)(1)(b) to schedule an initial evaluation.
- K.** If the Department receives the results of further diagnostic testing within 90 days from the date of the notice in subsection (H)(1), or the individual receives an initial evaluation within 90 days from the date of the notice in subsection (H)(1), the Department shall, within 14 days from the date of receipt of the results of further diagnostic testing or the completion of the individual's initial evaluation, make an eligibility determination and provide notice according to this Section.
- L.** If the Department does not receive the results of further diagnostic testing within 90 days from the date of the notice in subsection (H)(1), or the individual does not receive an initial evaluation within 90 days from the date of the notice in subsection (H)(1), as applicable, the Department shall consider the referral withdrawn.

R9-7-302. Enrollment

- A.** ~~An individual or, if the individual is a minor, the individual's parent may apply for enrollment after the individual or, if the individual is a minor, the individual's parent receives the notice in R9-7-301(D)(1) from the Department that the individual may be eligible for CRS.~~
- B.** ~~To apply for enrollment:~~
 - 1. ~~An applicant or, if the applicant is a minor, the applicant's parent shall submit to the Department an application form containing the information in R9-7-304(1);~~
 - 2. ~~An applicant or, if the applicant is a minor, the applicant's parent shall submit to the Department the documentation in R9-7-304(2) through (11):~~
 - a. ~~Before an applicant's initial evaluation; or~~
 - b. ~~No later than 10 business days after the date an applicant attends a CRS clinic for an initial evaluation;~~
 - 3. ~~After submitting the application form in subsection (B)(1):~~
 - a. ~~An applicant, or if the applicant is a minor, the applicant's parent shall participate in an eligibility interview; and~~
 - b. ~~An applicant shall attend a CRS clinic for an initial evaluation; and~~
 - 4. ~~No later than 10 business days after the date an applicant attends a CRS clinic for an initial evaluation, the applicant or, if the applicant is a minor, the applicant's parent shall:~~
 - a. ~~If the applicant is potentially eligible for Title XIX or Title XXI health care insurance, apply for the health care insurance; and~~
 - b. ~~Sign the payment agreement in R9-7-601(B).~~
- C.** ~~Except as provided in subsection (H), the Department shall enroll an applicant as soon as:~~
 - 1. ~~The applicant and, if applicable, the applicant's parent submit the information and documentation and meet the requirements in this Section; and~~
 - 2. ~~The Department determines the applicant is eligible for CRS.~~
- D.** ~~If the Department enrolls an applicant, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice that contains:~~
 - 1. ~~A statement that the applicant is enrolled in CRS; and~~
 - 2. ~~Information about CRS that includes:~~
 - a. ~~Covered medical services and covered support services;~~
 - b. ~~Member payment responsibility; and~~
 - e. ~~The grievance and appeal process.~~
- E.** ~~The Department shall not enroll an applicant if:~~
 - 1. ~~The applicant and, if the applicant is a minor, the applicant's parent does not submit the information and documentation or comply with the requirements in this Section; or~~
 - 2. ~~The Department determines that the applicant is not eligible for CRS.~~
- F.** ~~If the Department does not enroll an applicant, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice of denial that complies with A.R.S. § 41-1092.03.~~
- G.** ~~The Department shall provide the written notice in subsection (D) or subsection (F) within 10 days from the date of an applicant's initial evaluation or the Department's receipt of the applicant's information and documentation in subsection (B)(2) if the applicant did not submit the information and documentation at the applicant's initial evaluation, whichever is later.~~
- H.** ~~If an applicant, who meets the requirements in this Section and is determined to be eligible for CRS, is receiving inpatient services, the Department shall:~~
 - 1. ~~Provide the applicant or, if the applicant is a minor, the applicant's parent a written notice:~~
 - a. ~~Stating that the Department will not enroll an applicant while the applicant is receiving inpatient services; and~~

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- b. ~~Requesting that the Department is notified when the applicant is no longer receiving inpatient services; and~~
- 2. ~~When the applicant is no longer receiving inpatient services, enroll the applicant according to subsection (D).~~
- I. If the Department requests information or documentation to determine if a member remains eligible for CRS, the member or, if the member is a minor, the member's parent shall provide the requested information or documentation to the Department within 30 calendar days of the request.
- A. An applicant for enrollment in CRS shall submit:
 - 1. The following information:
 - a. The applicant's name, home address, mailing address, birth date, and marital status;
 - b. If the applicant has a Social Security number, the applicant's Social Security number;
 - c. Contact information for the applicant, such as a telephone number, cellular telephone number, or e-mail address;
 - d. Whether the applicant has a legal guardian;
 - e. Whether the applicant is an emancipated minor;
 - f. If the applicant is a minor, the following information for the applicant's parent:
 - i. Name, home address, mailing address, and contact information such as a telephone number, cellular telephone number, or e-mail address; and
 - ii. If the parent is employed, the parent's employer, work address, and work telephone number;
 - g. A statement that the applicant or, if the applicant is a minor, a parent on behalf of the applicant requests the applicant's enrollment in CRS; and
 - h. The signature of the applicant or, if the applicant is a minor, the signature of the applicant's parent, and the date signed;
 - 2. If the applicant has a legal guardian, a copy of the court document indicating the applicant's legal guardian;
 - 3. If the applicant is an emancipated minor, a copy of the court document indicating that the applicant is an emancipated minor;
 - 4. If the applicant has Title XIX or Title XXI health care insurance:
 - a. The applicant's valid AHCCCS identification number or a copy of the applicant's valid AHCCCS identification card; and
 - b. An assignment of Title XIX or Title XXI health care insurance benefits, as applicable, to the Department;
 - 5. If the applicant does not have Title XIX or Title XXI health care insurance:
 - a. Except as provided in subsection (A)(5)(b), as proof of the applicant's age and that the applicant is a U.S. citizen, a copy of any of the following documents that include the applicant's birth date:
 - i. A certified copy of a birth certificate,
 - ii. A naturalization certificate reflecting U.S. citizenship,
 - iii. A current or expired U.S. passport, or
 - iv. A certificate of U.S. citizenship;
 - b. If the applicant is a qualified alien, written documentation containing the applicant's birth date that verifies that the applicant:
 - i. Is a qualified alien, and
 - ii. Meets the requirements of A.R.S. § 36-2903.03(B);
 - c. As proof that the applicant resides in Arizona, a copy of any of the following documents, issued in the name of the applicant, the spouse of the applicant, or an adult with whom the applicant lives:
 - i. A United States Post Office record that contains the applicant's current Arizona address;
 - ii. An Arizona rent or mortgage receipt for the applicant's current Arizona address;
 - iii. An Arizona lease for the applicant's current Arizona address;
 - iv. A written statement that the applicant currently lives at an Arizona nursing care institution licensed under A.R.S. Title 36, Chapter 4, signed by the administrator of the Arizona nursing care institution;
 - v. A current Arizona motor vehicle operator's license;
 - vi. A current Arizona motor vehicle registration;
 - vii. A current pay stub from an Arizona employer;
 - viii. An Arizona utility bill for the applicant's current Arizona address;
 - ix. An Arizona telephone directory listing for the applicant's current Arizona address;
 - x. A certified copy of a religious record that contains the applicant's current Arizona address;
 - xi. A certified copy of a school record that contains the applicant's current Arizona address; or
 - xii. An affidavit signed by the applicant or, if the applicant is a minor, by the applicant's parent certifying that:
 - (1) None of the documents in subsections (A)(5)(c)(i) through (xi) are available, and
 - (2) The applicant currently lives in Arizona; and
 - d. Unless the application packet is being submitted for redetermination according to R9-7-307(A)(1), the applicable financial screening packet described in:
 - i. R9-7-303(A), or
 - ii. R9-7-303(B).

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- B.** The Department shall provide to an applicant within seven days from the date of the receipt of the application packet required in subsection (A) a written notice of:

 - 1. The Department's enrollment determination; and
 - 2. If applicable, the Department's determination of the applicant's payment responsibility.
- C.** If the Department determines that an applicant is eligible to enroll in CRS and has complied with the requirements in this Section, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent:

 - 1. A written notice that:
 - a. The applicant is eligible to enroll in CRS once the Department has received a completed payment agreement from the applicant; and
 - b. If the applicant does not submit to the Department a completed payment agreement within 90 days from the date of the notice, the Department shall consider the application withdrawn; and
 - 2. The payment agreement described in R9-7-304(A).
- D.** An applicant who is eligible to enroll in CRS and has complied with the requirements in this Section shall submit to the Department the completed payment agreement described in R9-7-304(A).
- E.** Except as provided in subsection (I), if the Department receives a completed payment agreement from an applicant who is eligible to enroll in CRS and has complied with the requirements in this Section, the Department shall:

 - 1. Enroll the applicant in CRS; and
 - 2. Provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice that:
 - a. The applicant is enrolled in CRS, and
 - b. Includes the name and contact information for the person the member can contact to schedule a medical service with a CRS provider.
- F.** If the Department determines that an applicant did not submit the information and documentation required in subsection (A):

 - 1. The Department shall provide a written notice to the applicant or, if the applicant is a minor, the applicant's parent that:
 - a. Identifies the missing information or documentation;
 - b. Requests the applicant or, if the applicant is a minor, the applicant's parent to submit the missing information or documentation within 90 days from the date of the notice; and
 - c. Informs the applicant or, if the applicant is a minor, the applicant's parent that, if the Department does not receive the information or documentation within 90 days from the date of the notice, the Department shall consider the application withdrawn.
 - 2. If the Department requests information or documentation according to subsection (F)(1) and receives the information or documentation requested within 90 days of the notice in that subsection, the Department shall, within seven days from the date of receipt of the requested information or documentation, make an enrollment determination and provide notice according to this Section.
- G.** If the Department determines that an applicant is not eligible to enroll in CRS, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent a written notice that:

 - 1. Informs the applicant or, if the applicant is a minor, the applicant's parent of the reason why the applicant is not eligible to enroll in CRS; and
 - 2. Complies with A.R.S. § 41-1092.03.
- H.** The Department shall consider an application withdrawn if the Department does not receive:

 - 1. The application packet required in subsection (A) within 90 days from the date of the notice in R9-7-301(E)(1).
 - 2. The information or documentation requested according to subsection (F)(1) within 90 days of the date of the notice in that subsection, or
 - 3. A completed payment agreement described in R9-7-304(A) within 90 days from the date of the notice in subsection (C)(1).
- I.** If the Department receives a completed payment agreement from an applicant who is eligible to enroll in CRS and has complied with the requirements in this Section and the applicant is receiving inpatient services, the Department shall:

 - 1. Provide the applicant or, if the applicant is a minor, the applicant's parent a written notice:
 - a. Stating that the Department will not enroll an applicant while the applicant is receiving inpatient services, and
 - b. Requesting that the Department be notified when the applicant is no longer receiving inpatient services; and
 - 2. When the Department receives notice that the applicant is no longer receiving inpatient services, enroll the applicant according to subsection (E).

R9-7-303. ~~Initial Evaluation; Further Diagnostic Testing~~ Financial Screening

~~If the Department determines from an applicant's initial evaluation that further diagnostic testing is required to determine whether the applicant is medically eligible for CRS, the Department shall:~~

- ~~1. If the applicant has Title XIX or Title XXI health care insurance, request that AHCCCS complete the diagnostic testing and send the results of the diagnostic testing to the Department;~~
- ~~2. If the applicant has other health care insurance that agrees to pay the Department for the diagnostic testing, complete~~

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- the diagnostic testing and submit charges for the diagnostic testing to the health insurance company;
3. If the applicant has health care insurance that does not agree to pay the Department for the diagnostic testing but provides the diagnostic testing, request that the applicant have:
 - a. The diagnostic testing completed through the applicant's health care insurance company, and
 - b. The results of the diagnostic testing sent to the Department; and
 4. If the applicant does not have health care insurance or has health care insurance that does not provide or pay for the diagnostic testing, and the applicant:
 - a. Signs the payment agreement in R9-7-601(B), provide the diagnostic testing to the individual; or
 - b. Does not sign the payment agreement in R9-7-601(B), provide to the applicant or, if the applicant is a minor, the applicant's parent a written notice of denial that complies with A.R.S. § 41-1092.03.

A. A financial screening packet for an individual who is not eligible for Title XIX or Title XXI health care insurance and is not applying for state funding under A.R.S. § 36-263 shall contain the following information:

1. The individual's name and birth date;
2. If the individual has a Social Security number, the individual's Social Security number;
3. A statement from the individual that the individual has reviewed the requirements provided by the Department for eligibility for Title XIX and Title XXI health care insurance, and the individual is not eligible for Title XIX or Title XXI health care insurance; and
4. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;

B. A financial screening packet for an individual who may be eligible for Title XIX or Title XXI health care insurance and is applying for state funding under A.R.S. § 36-263 shall contain:

1. The following information:
 - a. The individual's name and birth date;
 - b. If the individual has a Social Security number, the individual's Social Security number;
 - c. The individual's marital status;
 - d. The names and ages of all individuals in the individual's household income group;
 - e. The annual gross income of the individual's household income group;
 - f. Whether the individual has health care insurance other than Title XIX or Title XXI health care insurance;
 - g. If the individual has health care insurance other than Title XIX or Title XXI health care insurance, for each health care insurance company:
 - i. The health care insurance company's name, billing address, and telephone number; and
 - ii. For the individual's health care insurance, the individual's policy or plan number, health care insurance identification number, effective or end date, and type of services paid for by the health care insurance; and
 - h. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;
2. Copies of the following documentation for each individual in the individual's household income group, if applicable:
 - a. If the individual in the household income group is employed, the individual's:
 - i. Pay stubs for the 30 days before the date the applicant submitted the application packet required in R9-7-302(A), or
 - ii. If the individual cannot provide pay stubs, a written statement from the individual's employer confirming the individual's income from that employer;
 - b. If the individual in the household income group is self-employed, the individual's:
 - i. Federal tax return, including a schedule C, most recently filed by the individual; or
 - ii. Most recent quarterly financial statement signed and dated by the individual;
 - c. Documented evidence of all unearned income received by the individual, such as cancelled checks or court orders for child support payments; and
 - d. Documented evidence of all medical expenses incurred by the individual during the 12 months before the date the individual submitted the individual's CRS application;
3. If applicable, documented evidence of:
 - a. Any court award or settlement related to the individual's CRS condition, and
 - b. Expenditures from the court award or settlement made for medical services for the individual; and
4. If applicable, documented evidence of all current dependent care expenses for the individual, including:
 - a. The name and age of each dependent for whom the individual incurred dependent care expenses, and
 - b. The amount and frequency of dependent care expenses incurred for each dependent.

R9-7-304. Enrollment Application

An applicant applying for enrollment or, if the applicant is a minor, a parent applying on behalf of the applicant shall submit to the Department an application packet including:

1. An application form containing:
 - a. The applicant's name, home address, mailing address, birth date, place of birth, and marital status;

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- b. If the applicant has a social security number, the applicant's social security number;
 - e. If the applicant has a home telephone number, the applicant's home telephone number;
 - d. If the applicant does not have a home telephone number, a telephone number where a message may be left for the applicant;
 - e. Whether the applicant has a court-appointed legal guardian or custodian;
 - f. If the applicant is a minor, the following information for the applicant's parent:
 - i. Name;
 - ii. Home address, mailing address, and home or message telephone number;
 - iii. If the parent has a social security number, the parent's social security number; and
 - iv. If the parent works, the parent's employer, work address, and work telephone number;
 - g. The names and ages of all individuals in the applicant's household income group;
 - h. The annual gross income of the applicant's household income group;
 - i. Whether the applicant has Title XIX, Title XXI, or other health care insurance;
 - j. If the applicant has health care insurance other than Title XIX or Title XXI health care insurance, for each health care insurance company:
 - i. The health care insurance company's name, billing address, and telephone number; and
 - ii. For the applicant's health care insurance, the applicant's policy or plan number, health care insurance identification number, effective or end date, and type of services paid for by the health care insurance;
 - k. Whether the applicant receives services from the:
 - i. DES Adoption Subsidy Program;
 - ii. DES Comprehensive Medical and Dental Program; or
 - iii. DES Division of Developmental Disabilities;
 - l. The signature of the applicant or, if the applicant is a minor, the signature of the applicant's parent in subsection (1)(f); and
 - m. The date the application form is signed;
2. If the applicant has a legal guardian, a copy of the court document indicating the applicant's legal guardian;
3. If the applicant has Title XIX or Title XXI health care insurance, the applicant's AHCCCS identification number or a copy of the applicant's AHCCCS identification card;
4. If the applicant has health care insurance other than Title XIX or Title XXI health care insurance, a copy of the applicant's health care insurance card or written documentation that the applicant has health care insurance from the health care insurance company.
5. As proof of the applicant's age, a copy of one of the following documents that includes the applicant's birth date:
- a. An Immigration and Naturalization Service document;
 - b. A federal or state census record;
 - e. A hospital record of birth;
 - d. A certified copy of a birth certificate;
 - e. A military record;
 - f. A notification of birth registration;
 - g. A religious record;
 - h. A school record; or
 - i. A U.S. passport;
6. Except as provided in subsection (7), as proof of the applicant's U.S. citizenship, one of the following:
- a. A certified copy of a birth certificate;
 - b. A certified copy of a religious record issued within three months of birth;
 - e. A naturalization certificate reflecting U.S. citizenship;
 - d. A current or expired U.S. passport;
 - e. A certificate of U.S. citizenship; or
 - f. Documentation evidencing that the individual currently has Title XIX or Title XXI health care insurance;
7. If the applicant is a qualified alien, written documentation verifying that the applicant:
- a. Is a qualified alien, and
 - b. Meets the requirements of A.R.S. § 36-2903.03(B);
8. As proof that the applicant lives in Arizona, a copy of one of the following documents issued in the name of the applicant, the spouse of the applicant, or an adult with whom the applicant lives:
- a. The applicant's Title XIX or Title XXI health care insurance identification number or a copy of the applicant's current Title XIX or Title XXI health care insurance card;
 - b. An Arizona rent or mortgage receipt;
 - e. An Arizona lease for where the applicant lives;
 - d. A written statement that the applicant lives at an Arizona nursing care institution licensed under A.R.S. Title 36, Chapter 4 signed by the administrator of the Arizona nursing care institution;

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- e. An unexpired Arizona motor vehicle operator's license;
- f. A current Arizona motor vehicle registration;
- g. A pay stub from an Arizona employer;
- h. An Arizona utility bill for where the applicant lives;
- i. A current Arizona phone directory listing for where the applicant lives;
- j. A United States Post Office record reflecting an Arizona address;
- k. A certified copy of a religious record reflecting an Arizona address;
- l. A certified copy of a school record reflecting an Arizona address; and
- m. An affidavit signed by the applicant or, if the applicant is a minor, by the applicant's parent certifying that:
 - i. None of the documents in subsections (B)(8)(a) through (B)(8)(l) are available; and
 - ii. The applicant lives in Arizona;
- 9. As proof of an applicant's intent to continue to live in Arizona, an affidavit that contains an attestation by the applicant or, if the applicant is a minor, the applicant's parent of the applicant's intent to remain in Arizona;
- 10. If the applicant does not have Title XIX or Title XXI health care insurance, copies of the following documentation for each individual in the applicant's household income group, if applicable:
 - a. If an individual in the household income group is employed, the individual's:
 - i. Pay stubs for the 30 calendar days before the date on the applicant's application form;
 - ii. Most recent W-2 form; and
 - iii. Federal tax return most recently filed by the individual;
 - b. If an individual in the household income group is self-employed, the individual's:
 - i. Federal tax return, including a schedule C, most recently filed by the individual; or
 - ii. Most recent quarterly financial statement signed and dated by the individual;
 - e. Documented evidence of all unearned income received by an individual, such as cancelled checks or court orders for child support payments;
 - d. Documented evidence of all medical expenses incurred by an individual and paid during the 12 months before the date on the application form; and
 - e. Documented evidence of all unpaid medical expenses; and
- 11. If applicable, documented evidence of:
 - a. Any court award or settlement related to the applicant's CRS condition; and
 - b. Expenditures from the court award or settlement made for medical services for the applicant.

R9-7-604. R9-7-304. Member Payment Responsibility

- A.** A member shall pay the cost for covered medical services provided by the Department up to the total amount of any:
 - 1. Court award or settlement of a claim for the member's CRS condition less money from the court award or settlement expended for medical services for the member;
 - 2. Health care insurance payment or reimbursement to which the member is entitled for covered medical services; and
 - 3. Other third party payment or reimbursement to which the member is entitled for covered medical services;
- B.** Except as provided in subsection (A), the Department shall not require a member whose household income group's net income is equal to or less than 200% of the Federal Poverty Level to pay for a covered medical service, except the Department may charge the member a \$5.00 co-payment for the non-emergency use of a hospital's emergency services to treat a CRS condition.
- A.** A payment agreement shall contain the following information:
 - 1. The individual's or member's name;
 - 2. The individual's or member's date of birth;
 - 3. If the Department has determined the individual's or member's payment responsibility, the individual's or member's payment responsibility;
 - 4. A promise to pay the cost of covered medical services not paid by any third-party payor;
 - 5. An assignment of insurance benefits; and
 - 6. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;
- B.** The Department shall determine an individual's or member's payment responsibility for covered medical services by:
 - 1. Identifying the individual's or member's household income group;
 - 2. Calculating the net income of the individual's or member's household income group; and
 - 3. Determining whether the net income of the individual's or member's household income group is:
 - a. Less than the percentage established according to subsection (C), or
 - b. Greater than or equal to the percentage established according to subsection (C).
- C.** The Department shall establish annually, based on the amount of funding appropriated to CRS under A.R.S. §§ 36-261(A)(5)(h) and 36-261(A)(5)(l) and the Department's projected cost to administer CRS and provide covered medical services and covered support services for the subsequent 12 months, the percentage of the Federal Poverty Level to be used to determine an individual's or member's payment responsibility according to this Section.

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D. The Department shall not require an individual, whose household income group's net income is less than the percentage established according to subsection (C), to pay for a covered medical service.

~~**E.** A member An individual whose household income group's net income is greater than 200% of the Federal Poverty Level or equal to the percentage established according to subsection (C) shall pay for a covered medical service an amount not to exceed the AHCCCS capped fee-for-service rate for the covered medical service.~~

~~**R9-7-602. R9-7-305. Identification of Household Income Group**~~

- A.** No change
1. No change
 2. No change
 3. No change
- B.** The Department shall consider any of the following, when living together, a household income group as a household income group any of the following who are living together:
1. No change
 2. No change
 3. No change
 4. No change
 5. No change
 6. No change
 7. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
- C.** In addition to the individuals in subsection (B), the Department shall include in a household income group an individual who is not living with the household if:
1. The individual is absent from the household; for 30 calendar days or less;
 - a. For 30 consecutive days or less;
 - b. To seek or maintain employment;
 - c. To serve in the military; or
 - d. To attend an educational institution, and the parent of the individual claims the individual as a dependent on the parent's income tax return; or
 2. ~~The individual contributes to the income of the household; or~~
 - 3-2. The parent of the individual claims the individual as a dependent on the parent's income tax return.

~~**R9-7-603. R9-7-306. Calculating Net Income**~~

- A.** Except as provided in subsection (B), a household income group's gross income includes all the earned income and unearned income of the individuals in the household income group.
1. For an individual in the household income group who is not self-employed, the Department shall calculate an individual's ~~annual~~ income using the ~~pay stubs required in R9-7-304(10)(a)(i); and documents required in R9-7-303(B)(2)(a); and~~
 2. For an individual in the household income group who is self-employed, the Department shall calculate an individual's ~~annual~~ income using the individual's federal tax return or most recent quarterly financial statement required in ~~R9-7-304(10)(b); R9-7-303(B)(2)(b).~~
- B.** Gross income does not include:
1. The items in ~~A.C.C. R9-22-1419(C)~~ A.A.C. R9-22-1420(C), and
 2. The first \$50.00 per month per child of child support payments ~~paid~~ received by an individual in the household income group.
- C.** When calculating net income, the Department shall deduct the following from the gross income of the household income group ~~described in R9-7-602 R9-7-305:~~
1. For each month the household income group received earned income, a deduction for dependent care that is equal to the AHCCCS allowable deduction in ~~A.A.C. R9-22-1429(E)(2), if the individual who received the earned income and A.A.C. R9-22-1420(F)(2)(b), if the individual who received dependent care are~~ is living in the household;
 2. No change
 - 3- ~~The following medical expenses:~~
 - a- ~~Unpaid medical expenses that are:~~
 - i- ~~Incurred by any individual in the household income group before an application form is submitted or a re-termination is requested; and~~
 - ii- ~~Not subject to any applicable third party payment or reimbursement; and~~
 - b- ~~Medical expenses for any individual in the household income group that are:~~

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- i. ~~Paid by an individual in the household income group during the 12 months before an application form is submitted or a redetermination is requested, and~~
 - ii. ~~Not subject to any third party payment or reimbursement.~~
3. Medical expenses that are:
- a. Incurred by the individual during the 12 months before the individual submitted to the Department the application packet required in R9-7-302(A), and
 - b. Not subject to any third-party payment or reimbursement.

~~R9-7-305. R9-7-307. Redetermination~~

- ~~A. At any time, the Department may request a member or, if the member is a minor, the member's parent to submit the information and documents in R9-7-304 to redetermine:
 - 1. Whether a member remains eligible for CRS, or
 - 2. A member's payment responsibility.~~
- ~~B. If the member has Title XIX or Title XXI health care insurance, the Department shall, no later than the member's CRS expiration date:
 - 1. Verify that the member has Title XIX or Title XXI health care insurance, and
 - 2. Establish a new CRS expiration date for the member that is the same as the member's Title XIX or Title XXI health care insurance expiration date.~~
- ~~C. If the member does not have Title XIX or Title XXI health care insurance and the net income of the member's household income group is more than 200% of the Federal Poverty Level, the member or, if the member is a minor, the member's parent shall submit, before the member's CRS expiration date, a signed payment agreement.~~
- ~~D. If the member does not have Title XIX or Title XXI health care insurance and the net income of the member's household income group is equal to or less than 200% of the Federal Poverty Level, the member or, if the member is a minor, the member's parent shall, at least 30 calendar days before the CRS expiration date:
 - 1. Participate in an eligibility interview with a Department representative,
 - 2. Submit to the Department the information and documentation in R9-7-304(10), and
 - 3. Submit to the Department a signed payment agreement.~~
- ~~E. The Department shall establish a new CRS expiration date for a member who does not have Title XIX or Title XXI health care insurance that is 12 months after the member's CRS expiration date if:
 - 1. The member and, if the member is a minor, the member's parent comply with the redetermination requirements in this Section before the member's expiration date; and
 - 2. The Department determines that the member remains eligible for CRS.~~
- ~~F. If the Department determines that a member is no longer eligible for CRS, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:
 - 1. Informs the member that the member is no longer eligible for CRS, and
 - 2. Complies with A.R.S. § 41-1092.03.~~
- ~~G. At any time, a member or, if the member is a minor, the member's parent may request a redetermination of the member's payment responsibility by submitting to the Department:
 - 1. A written request for redetermination, and
 - 2. The documentation and information in R9-7-304(10).~~
- ~~H. Within 30 calendar days from the date of the Department's receipt of a member's request for redetermination, the Department shall provide the member or, if the member is a minor, the member's parent:
 - 1. A written notice of the Department's redetermination;
 - 2. A new CRS expiration date for the member; and
 - 3. If applicable, a revised payment agreement.~~
- ~~I. If the Department changes a member's payment responsibility as a result of a redetermination, and the member does not have Title XIX or Title XXI health care insurance, the member or, if the member is a minor, the member's parent shall sign and submit a revised payment agreement.~~
- A. At any time, the Department may, to redetermine whether a member remains eligible for CRS or a member's payment responsibility, request that a member or, if the member is a minor, the member's parent submit all or part of the following information or documentation:
 - 1. To determine whether a member remains eligible for CRS, the application packet required in R9-7-302(A);
 - 2. If the member does not have Title XIX or Title XXI health care insurance, to determine a member's payment responsibility, the financial screening packet described in R9-7-303; or
 - 3. If the member has Title XIX or Title XXI health care insurance, to determine whether the member remains eligible for AHCCCS, the member's valid AHCCCS identification number or a copy of the member's valid AHCCCS identification card.
- B. The Department shall provide written notice of the Department's request in subsection (A) to the member or, if the member is a minor, the member's parent:
 - 1. Requesting all or part of the information or documentation described in subsection (A); and

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2. Informing the member or, if the member is a minor, the member's parent that if the Department does not receive the information or documentation in subsection (A) within 30 days from the date of the notice, the Department:
 - a. Will not provide a covered service to the member; and
 - b. If applicable, may terminate the member's enrollment according to R9-7-308.
- C. The Department shall, at least once every 12 months:
 1. If a member does not have Title XIX or Title XXI health care insurance, redetermine a member's payment responsibility; or
 2. If a member has Title XIX or Title XXI health care insurance, redetermine whether a member remains eligible for Title XIX or Title XXI health care insurance.
- D. If the Department sends the notice in subsection (B), the member or, if the member is a minor, the member's parent shall submit the requested information or documentation to the Department within 30 days of the request.
- E. If the Department receives the information in subsection (A)(1) from the member within 30 days, the Department shall determine the member's eligibility as provided in Article 2.
- F. If the Department does not receive the information or documentation in subsection (A)(1) from the member within 30 days, or the Department determines that a member is no longer eligible for CRS, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:
 1. Informs the member that the Department is terminating the member's enrollment according to R9-7-308 because:
 - a. The Department has determined that the member is no longer eligible for CRS, or
 - b. The member did not comply with the requirements in R9-7-307 to verify that the member remains eligible for CRS; and
 2. Complies with A.R.S. § 41-1092.03.
- G. If the Department receives the information or documentation in subsection (A)(2) from the member and, if applicable, the information or documentation is received within 30 days from the date of the notice in subsection (B), the Department shall redetermine the member's payment responsibility for covered medical services by:
 1. Identifying the individual's or member's household income group;
 2. Calculating the net income of the individual's or member's household income group;
 3. Determining whether the net income of the member's household income group is:
 - a. Less than the highest percentage established according to R9-7-304(C) since the member most recently enrolled in CRS, or
 - b. Greater than or equal to the highest percentage established according to R9-7-304(C) since the member most recently enrolled in CRS.
- H. If the Department does not receive the information or documentation in subsection (A)(2) within 30 days, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that the member is required to comply with the requirements in this Section before the Department provides a covered service to the member.
- I. If the Department determines that a member who does not have Title XIX or Title XXI health care insurance may be eligible for Title XIX or Title XXI health care insurance, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:
 1. The member is required to apply for Title XIX or Title XXI health care insurance;
 2. If the member does not apply for Title XIX or Title XXI health care insurance within six months after the date of the notice, the Department may terminate the member's enrollment; and
 3. The member is required to apply for Title XIX or Title XXI health care insurance before the Department will provide a covered service to the member.
- J. If the Department sends the notice in subsection (I), the member shall apply for Title XIX or Title XXI health care insurance:
 1. Before the Department will provide a covered service to the member; or
 2. Within six months after the date of the notice, if the member is not scheduled to receive a covered service within six months after the date of the notice.
- K. At any time, a member or, if the member is a minor, the member's parent may request a redetermination of the member's payment responsibility by submitting to the Department:
 1. A written request for redetermination, and
 2. The information or documentation in subsection (A)(2).
- L. Within 30 days from the date of the Department's determination under subsection (G), the Department shall provide the member or, if the member is a minor, the member's parent:
 1. A written notice of the Department's redetermination; and
 2. If applicable, a revised payment agreement.
- M. If the Department changes a member's payment responsibility as a result of a redetermination, and the member does not have Title XIX or Title XXI health care insurance, the member or, if the member is a minor, the member's parent shall sign and submit a revised payment agreement before the Department provides a covered service to the member.
- N. The Department shall consider a member to have been enrolled in CRS during any period of 90 days or less in which the

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member was not enrolled in CRS for the purpose of redetermining the member's payment responsibility according to this Section.

~~R9-7-306.~~ R9-7-308. Termination of Enrollment

- A. The Department shall terminate a member's enrollment if:
1. The Department determines the member ~~no longer meets~~ does not meet the eligibility requirements in R9-7-201;
 2. ~~A member does not continue to have Title XIX or Title XXI health care insurance while the member is eligible for the Title XIX or Title XXI health care insurance; or~~
The member does not attend the member's first scheduled appointment with a CRS provider after enrollment; or
 3. The member or, if the member is a minor, the member's parent:
 - a. No change
 - b. Fails to comply with the:
 - i. ~~Submission requirements in R9-7-302(I) or R9-7-305; or~~
The requirements in R9-7-307, or
 - ii. ~~Signed payment agreement in R9-7-601(B), if applicable.~~
The signed payment agreement described in R9-7-304(A).
- B. No change
1. No change
 2. No change

ARTICLE 4. COVERED MEDICAL SERVICES

R9-7-401. General Requirements

- ~~A. The Department shall not provide covered medical services other than an initial evaluation until the individual and, if the individual is a minor, the individual's parent comply with the application requirements in R9-7-302(B) and the Department determines that the individual meets the eligibility requirements in R9-7-201.~~
- ~~B. The Department shall provide a covered service in this Section:~~
1. ~~Through a regional contractor;~~
 2. ~~At the regional contractor's facility or a facility under contract with the regional contractor; and~~
 3. ~~Using a CRS provider.~~
- ~~C. The Department shall provide a medical service in R9-7-403 through R9-7-421 to a member if:~~
1. ~~A regional medical director or the regional medical director's designee determines that the medical service:~~
 - a. ~~Is medically necessary;~~
 - b. ~~Is related to the member's CRS condition; and~~
 - e. ~~Except as provided in subsection (D), is not to treat one of the conditions in R9-7-203; and~~
 2. ~~A CRS provider obtains prior authorization, if applicable according to R9-7-402, for the medical service.~~
- ~~D. If the requirements of subsection (C) are met, the Department shall provide a medical service to a member to treat the following medical conditions:~~
1. ~~Sinusitis for a member with cystic fibrosis;~~
 2. ~~An ingrown toenail if secondary to a CRS condition;~~
 3. ~~Strabismus for a member with cerebral palsy, myelomeningocele, a shunt, a cataract, glaucoma, a disorder of the optic nerve, retinopathy of prematurity, or a disorder of the iris, ciliary bodies, retina, lens or cornea;~~
 4. ~~Enuresis if secondary to a CRS condition;~~
 5. ~~Otitis media in a member with cleft lip and cleft palate or a sensorineural hearing loss;~~
 6. ~~Nasal polyps for a member with cystic fibrosis;~~
 7. ~~Malabsorption syndrome for a member with cystic fibrosis;~~
 8. ~~Nephritis associated with lupus erythematosus;~~
 9. ~~Hydrocele associated with a ventriculo-peritoneal (VP) shunt;~~
 10. ~~A fracture caused by a CRS condition;~~
 11. ~~Bunions if secondary to a CRS condition;~~
 12. ~~Carpal tunnel syndrome if secondary to a CRS condition;~~
 13. ~~Refraction error for a member with an ophthalmologic CRS condition;~~
 14. ~~Astigmatism for a member with an ophthalmologic CRS condition; or~~
 15. ~~With medication for no more than 30 calendar days, depression secondary to a CRS condition.~~
- ~~E. If a member requires a medical service that meets the requirements of subsection (C) and the medical service is not available in Arizona, the Department shall provide the medical service in another state if:~~
1. ~~Two physicians, who are CRS providers, practicing a specialty related to the member's CRS condition, each submit in writing to the Department:~~
 - a. ~~A recommendation that the Department provide the medical service in another state; and~~
 - b. ~~A statement that:~~
 - i. ~~The medical service is life-saving for the member, and~~

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- ii. ~~The member is anticipated to experience, as a result of the medical service, functional improvement and that the physician expects the functional improvement to be significant; and~~
- 2. ~~A regional medical director and a regional contractor provide written authorization to the Department before the provision of the medical service outside the state of Arizona.~~
- F.** ~~If the Department provides a member a medical service in another state, the Department shall not provide transportation or lodging for the member or the member's family.~~
- G.** ~~If a member receives a recommendation for treatment from a CRS provider, the member may obtain a recommendation for treatment from a second CRS provider.~~
- H.** ~~The Department shall provide the following medical services to a member beyond the limit specifically stated in the applicable subsection if approved by a regional medical director:~~
 - 1. ~~Home health services in R9-7-406(B);~~
 - 2. ~~Oxygen and related supplies in R9-7-408(G);~~
 - 3. ~~Nutrition services in R9-7-410(A);~~
 - 4. ~~Physical therapy and occupational therapy in R9-7-413;~~
 - 5. ~~Psychological services in R9-7-416(A);~~
 - 6. ~~Psychiatric services in R9-7-417(A); and~~
 - 7. ~~Speech/language pathology services in R9-7-419.~~
- A.** Except as provided in R9-7-307(J) and (M), the Department shall provide a medical service described in R9-7-402 through R9-7-420 to a member if the Department determines that the medical service:
 - 1. Is medically necessary.
 - 2. Is related to the member's CRS condition, and
 - 3. Is provided consistent with utilization management practices established by the Department.
- B.** If a member requires a medical service that meets the requirements of subsection (A) and the medical service is not available in Arizona, the Department shall provide the medical service in another state if:
 - 1. Two physicians, who are CRS providers, practicing a specialty related to the member's CRS condition, each submit in writing to the Department:
 - a. A recommendation that the Department provide the medical service in another state; and
 - b. A statement that:
 - i. The medical service is life-saving for the member; or
 - ii. The member is expected to experience, as a result of the medical service, significant functional improvement; and
 - 2. A physician who is the Department's designee provides written authorization before the provision of the medical service outside the state of Arizona.
- C.** The Department may provide a medical service in a state that borders Arizona if the member's residence is closer to a CRS provider in the state that borders Arizona than to a CRS provider located within Arizona.
- D.** If the Department provides a member a medical service in another state, the Department shall not provide:
 - 1. Lodging for the member or member's family;
 - 2. Transportation for a member's family; or
 - 3. Transportation for a member, except as provided in R9-7-406(B).
- E.** If the Department receives from a member, who received a recommendation for treatment from a CRS provider, a request for a second recommendation for treatment, the Department shall:
 - 1. Provide a second recommendation for treatment from a different CRS provider; or
 - 2. If the Department is unable to provide a second recommendation for treatment from a different CRS provider, provide a second recommendation for treatment from another provider other than a CRS provider designated by the Department.

R9-7-402: Prior Authorization

Except in an emergency, a CRS provider shall obtain prior authorization before providing any of the following to a member:

- 1. ~~Medical equipment in R9-7-408;~~
- 2. ~~Prosthetic and orthotic devices in R9-7-415;~~
- 3. ~~Physician services in R9-7-414 provided at a physician's office;~~
- 4. ~~Dental services in R9-7-404 provided at a dentist's office;~~
- 5. ~~Outpatient diagnostic testing and laboratory services in R9-7-411(2) not provided by a CRS provider;~~
- 6. ~~Outpatient surgery in R9-7-411(1);~~
- 7. ~~An outpatient positive emission tomography scan;~~
- 8. ~~An implantable bone conduction device in R9-7-403(B)(7);~~
- 9. ~~A tactile hearing aid in R9-7-403(B)(8); and~~
- 10. ~~Admission to a hospital for inpatient services in R9-7-407.~~

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~~R9-7-403.~~ R9-7-402. Audiology Services

- A. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide audiology services to a member who has, as determined by a CRS provider, a:
1. No change
 2. No change
- B. If the requirements in subsection (A) are met, the Department shall provide the following audiology services:
1. No change
 2. No change
 3. No change
 4. No change
 5. No change
 6. No change
 - a. No change
 - b. No change
 - c. No change
 7. An implantable bone conduction device; ~~and~~
 8. A cochlear implant; and
 - ~~8-9. A tactile hearing aid.~~
- ~~C. The Department shall not provide a cochlear implant to a member.~~

~~R9-7-404.~~ R9-7-403. Dental and Orthodontia Services

- A. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide dental services to a member who has one of the following medical conditions:
1. No change
 2. No change
 3. No change
 4. No change
 5. No change
 6. No change
 - a. No change
 - b. No change
 - c. No change
- B. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide orthodontia services and devices to a member who has one of the following medical conditions:
1. No change
 2. No change
 - a. No change
 - b. No change
 - c. No change

~~R9-7-405.~~ R9-7-404. Diagnostic Testing and Laboratory Services

- A. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide ~~the following diagnostic testing to a member:~~ diagnostic testing or laboratory services to a member as ordered by a CRS provider.
- ~~1. Radiology;~~
 - ~~2. Visual evoked response;~~
 - ~~3. Computed tomography scan;~~
 - ~~4. Ultrasound;~~
 - ~~5. Brainstem auditory evoked response;~~
 - ~~6. Magnetic resonance imaging;~~
 - ~~7. Electroencephalogram;~~
 - ~~8. Electrocardiogram; and~~
 - ~~9. Echocardiogram.~~
- B. If the requirements of ~~R9-7-401(C)~~ are met, the Department shall provide the following laboratory services to a member:
- ~~1. A blood bank, accessible to the member;~~
 - ~~2. Pulmonary function testing;~~
 - ~~3. Complete blood counts; and~~
 - ~~4. Urinalysis.~~
- ~~C.B.~~ The Department shall provide diagnostic testing and laboratory services, as ordered by a ~~physician~~ CRS provider, ~~to a member to determine if the a member has a CRS condition in addition to the CRS condition diagnosed at the member's initial evaluation.~~ time of the member's enrollment.

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~~R9-7-406.~~ **R9-7-405. Home Health Services**

- A. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide total parenteral nutrition to a ~~member~~ for no more than 30 calendar days before the member's hospitalization for member, as ordered by a CRS provider, in preparation for a procedure or surgery related to the member's CRS condition.
- ~~B.~~ If the requirements in ~~R9-7-401(C)~~ are met, ~~the Department shall provide home health services to a member after the member's hospitalization:~~
- ~~1. If a CRS provider requests that the home health services be provided where the member is located;~~
 - ~~2. If the need for home health services is related to the member's CRS condition that was treated during the member's hospitalization; and~~
 - ~~3. Except as provided in R9-7-401(G) for no more than 30 calendar days.~~
- ~~C.B.~~ If the requirements in ~~subsection (B)~~ R9-7-401 are met, after a member's hospitalization, or instead of hospitalization, the Department shall provide the following home health services:
1. No change
 2. No change
 3. No change
 4. No change
 5. No change
 6. No change
 7. No change
 8. No change
 9. No change
 10. No change
 11. No change

~~R9-7-407.~~ **R9-7-406. Inpatient Services**

- A. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide inpatient services to a member who requires hospitalization related to the member's CRS condition.
1. If, after being hospitalized, a member's hospitalization is no longer related to the member's CRS condition or to complications related to the member's treatment for the member's CRS condition, the Department shall not provide inpatient services to the member.
 2. If a member requires inpatient services to determine whether the member has ventricular infection or ventricular shunt failure, the Department shall provide inpatient services until the date the ~~regional medical director or the regional medical director's~~ physician who is the Department's designee determines that the member does not have ventricular infection or ventricular shunt failure.
- B. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide transportation for a member who is receiving inpatient services from one a hospital that is a CRS provider to another hospital that is a CRS provider, if:
- ~~1. Ordered by a CRS provider, and~~
 - ~~2. Authorized in writing by a regional medical director.~~

~~R9-7-408.~~ **R9-7-407. Medical Equipment**

- A. ~~If the requirements of R9-7-401(C) are met and subject to the limitations in subsections (B) through (D), the Department shall provide a non-motorized wheelchair or an ambulation assistive device to a member.~~
- ~~B.~~ ~~The Department shall provide a tilt-in-space wheelchair to a member only if a change in the member's position is necessary to provide medically necessary services such as tracheotomy care or feeding.~~
- ~~A.~~ If the requirements in R9-7-401 are met and subject to the limitations in this Section, the Department shall provide the medical equipment indicated in this Section to a member as ordered by a CRS provider.
- ~~B.~~ The Department shall provide to a member:
1. A wheelchair.
 2. An ambulation assistive device, or
 3. A tilt-in-space wheelchair only if a change in the member's position is necessary to provide medically necessary services such as tracheotomy care or feeding.
- C. No change
1. No change
 2. No change
 3. No change
- D. No change
- E. No change
1. No change
 2. No change
 3. No change

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- F. No change
- ~~G.~~ Except as provided in R9-7-401(G), the Department shall provide oxygen and related supplies for no more than 30 calendar days to a member if ordered by a CRS provider.
- ~~G.~~ Unless approved by a physician who is the Department's designee, the Department shall provide oxygen and related services for no more than 30 consecutive days to a member.
- H. No change
 - 1. No change
 - 2. No change
- I. Except as provided in subsection (K), in ~~an~~ addition to subsection (H), the Department shall replace medical equipment provided to a member if the medical equipment:
 - ~~1. Is not safe to operate and cannot be repaired to be safe to operate as determined by a CRS provider;~~
 - 1. As determined by a CRS provider, is not safe to operate and cannot be repaired to be safe to operate;
 - 2. No change
 - a. No change
 - b. No change
 - 3. No change
- ~~J.~~ The Department shall make a repair to a member's medical equipment if:
 - ~~1. A written determination by a CRS provider that the repair to the medical equipment is medically necessary for the member is submitted to the Department;~~
 - ~~2. The need for repair is not due to the member's misuse of the medical equipment; and~~
 - ~~3. The repair is to:~~
 - ~~a. Medical equipment provided by the Department; or~~
 - ~~b. A wheelchair that, although not provided to the member by the Department, has been determined by a CRS provider to be safe and appropriate for the member.~~
- ~~J.~~ Except as provided in subsection (K), the Department shall repair a member's medical equipment if:
 - 1. The Department determines that the medical equipment, if not repaired, would be provided according to this Section;
 - 2. The Department determines that the repair to the medical equipment is medically necessary; and
 - 3. The repair is to:
 - a. Medical equipment provided by the Department; or
 - b. Medical equipment that, although not provided to the member by the Department, has been determined by a CRS provider to be safe, appropriate, and medically necessary for the member.
- ~~K.~~ The Department shall not repair or replace medical equipment according to subsection (I) or (J) if the need for repair or replacement is due to the member's misuse of the medical equipment.

~~R9-7-409.~~ **R9-7-408. Nursing Services**

If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide nursing services to a member.

~~R9-7-410.~~ **R9-7-409. Nutrition Services**

- A. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide the following nutrition services to a member:
 - 1. No change
 - 2. No change
 - 3. If ordered by a CRS provider:
 - a. No change
 - ~~b. For providing nutrition through a tube;~~
 - ~~i. Equipment; and~~
 - ~~ii. Except as provided in R9-7-401(G), a commercial product for no more than 30 calendar days; and~~
 - b. Medical equipment or a commercial product for providing nutrition through a tube; and
 - 4. If ordered by a CRS provider for a member with cystic fibrosis, and not available through a source other than CRS, a commercial product:
 - a. For a member who is not receiving nutrition through a tube, that supplies 50% of the member's daily caloric need; and
 - b. No change
 - ~~e. Except as provided in R9-7-401(G), for no more than 30 calendar days.~~
- B. No change
 - 1. No change
 - 2. No change
 - 3. No change

~~R9-7-411.~~ **R9-7-410. Outpatient Services**

If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide the following outpatient services to a

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member:

1. Outpatient surgery by a CRS provider;
2. Diagnostic testing and laboratory services allowed in ~~R9-7-405~~ R9-7-404;
3. Emergency services in a hospital that is a CRS provider;
4. No change
5. Evaluation and treatment by a CRS provider at a location other than a CRS clinic. at:
 - a. ~~An outreach clinic, or~~
 - b. ~~A regional clinic.~~

~~R9-7-412.~~ R9-7-411. Pharmaceutical Services

- A. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide pharmaceutical services to a member.
- B. The Department shall provide growth hormone therapy ordered by a physician only for a member who has been diagnosed by a CRS provider with panhypopituitarism.

~~R9-7-413.~~ R9-7-412. Physical Therapy and Occupational Therapy

- A. ~~If the requirements of R9-7-401(C) are met, the Department shall provide physical therapy or occupational therapy to a member only:~~
 1. ~~Before a scheduled surgery;~~
 2. ~~After a surgery;~~
 3. ~~After removal of a cast;~~
 4. ~~If a medication used to treat the member's CRS condition causes impairment to a neurologic or orthopedic function;~~
 5. ~~After the member receives an orthotic or prosthetic device;~~
 6. ~~After a hospitalization; and~~
 7. ~~If the member:~~
 - a. ~~Is unable to obtain physical therapy or occupational therapy through a source other than CRS, and~~
 - b. ~~Has a strong potential rehabilitation as determined by a CRS provider.~~
- B. ~~Except as provided in R9-7-401(G), the Department shall provide no more than 24 sessions of physical therapy or 24 sessions of occupational therapy for each occurrence in subsection (A).~~

If the requirements in R9-7-401 are met, the Department shall provide physical therapy or occupational therapy to a member only if the member:

1. Is unable to obtain physical therapy or occupational therapy through a source other than CRS or another health care insurance provider, and
2. Is expected to experience a functional improvement as a result of the physical therapy or occupational therapy.

~~R9-7-414.~~ R9-7-413. Physician Services

If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide physician services to a member.

~~R9-7-415.~~ R9-7-414. Prosthetic and Orthotic Devices

- A. If the requirements of ~~R9-7-401(C)~~ in R9-7-401 are met, and subject to the limitations in subsection (B), the Department shall provide a prosthetic device or an orthotic device to a member to enhance the member's ability to perform an activity of daily living.
- B. No change
 1. No change
 2. No change
- C. The Department shall replace or ~~make a change to~~ a prosthetic device or orthotic device provided to a member if the replacement or change is:
 1. No change
 2. No change
- D. ~~The Department shall make a repair to a prosthetic device or orthotic device provided by the Department if:~~
 1. ~~The repair is determined to be medically necessary by a CRS provider, and~~
 2. ~~The need for repair is not due to the member's misuse of the prosthetic device or orthotic device.~~
- D. Except as provided in subsection (F), and in addition to subsection (C), the Department shall replace a prosthetic device or orthotic device provided to the member if the prosthetic device or orthotic device:
 1. As determined by a CRS provider, is not safe to operate and cannot be repaired to be safe to operate;
 2. Is stolen and the member or, if the member is a minor, the member's parent submits to the Department:
 - a. A written request for a replacement prosthetic device or orthotic device, and
 - b. A copy of a police report about the stolen prosthetic device or orthotic device; or
 3. Is lost and has not been replaced by the Department within the previous 12 months due to loss.
- E. ~~In addition to subsection (C), the Department shall replace a prosthetic device or orthotic device provided to the member if the prosthetic device or orthotic device:~~

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1. Is stolen and the member or, if the member is a minor, the member's parent submits to the Department:
 - a. A written request for a replacement prosthetic device or orthotic device; and
 - b. A copy of a police report about the stolen prosthetic or orthotic device; or
2. Is lost and the prosthetic device or orthotic device has not been replaced by the Department within the previous 12 months due to loss.

E. Except as provided in subsection (F), the Department shall repair a prosthetic device or orthotic device provided to a member by the Department if the Department determines that the repair is safe, appropriate, and medically necessary for the member.

F. The Department shall not replace or repair a prosthetic device or orthotic device according to subsection (D) or (E) if the need for replacement or repair is due to the member's misuse of the prosthetic device or orthotic device.

~~R9-7-416.~~ R9-7-415. Psychological Services

A. If the requirements of ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide the following psychological services to a member:

1. No change
2. No change
3. No change

B. ~~Except as provided in R9-7-401(G), the number of sessions in subsection (A) provided to a member shall not exceed three per calendar year.~~

B. Unless approved by a physician who is the Department's designee, the Department shall not provide more than three sessions in subsection (A) per year.

~~R9-7-417.~~ R9-7-416. Psychiatric Services

A. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide psychiatric services to a member who has received an evaluation and recommendation for psychiatric services from a psychologist who is a CRS provider.

B. ~~Except as provided in R9-7-401(G), the number of sessions provided to a member according to subsection (A) shall not exceed one per calendar year.~~

B. Unless approved by a physician who is the Department's designee, the Department shall not provide more than one session in subsection (A) per year.

~~R9-7-418.~~ R9-7-417. Social Work Services

The Department shall provide the following social work services to a member or the member's family:

1. An initial psychosocial evaluation performed by a social worker ~~within the member's first three visits to a CRS clinic, regional clinic, or outreach clinic~~ no later than the date of the member's third visit to a CRS provider;
2. Subsequent psychosocial evaluations of a member and the member's family performed by a social worker based on the initial psychological evaluation and as needed throughout the member's enrollment; and
3. No change

~~R9-7-419.~~ R9-7-418. Speech/Language Pathology Services

A. ~~If the requirements in R9-7-401(C) are met, the Department shall provide speech/language pathology services to a member:~~

1. ~~Before a scheduled surgery;~~
2. ~~After a surgery;~~
3. ~~If a medication used to treat the member's CRS condition causes neurological impairment;~~
4. ~~After a hospitalization; and~~
5. ~~If the member is not able to obtain speech/language pathology services through a source other than CRS.~~

B. ~~Except as provided in R9-7-401(G), the Department shall provide no more than 24 sessions of speech/language pathology services for each occurrence in subsection (A).~~

If the requirements in R9-7-401 are met, the Department shall provide speech/language pathology services to a member only if the member:

1. Is unable to obtain speech/language pathology services through a source other than CRS or another health care insurance provider, and
2. Is expected to experience a functional improvement as a result of the speech/language pathology services.

~~R9-7-420.~~ R9-7-419. Transplants

If the requirements of ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide a corneal transplant or a bone-grafting transplant to a member.

~~R9-7-421.~~ R9-7-420. Vision Services

If the requirements of ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide the following vision services to a member:

1. No change

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2. No change
3. No change
4. No change
5. No change

R9-7-421. Renumbered

ARTICLE 5. COVERED SUPPORT SERVICES

~~R9-7-501.~~ General Requirements

The Department shall provide a support service in this Section:

- ~~1. Through a regional contractor;~~
- ~~2. At the regional contractor's facility or a facility under contract with the regional contractor; and~~
- ~~3. Using a CRS provider.~~

~~R9-7-502.~~ R9-7-501. Advocacy Services

The Department shall provide the following advocacy services:

1. Explaining the CRS application requirements in ~~R9-7-302(B)~~ R9-7-302 to an applicant or, if the applicant is a minor, the applicant's parent and assisting the applicant or applicant's parent in completing the application;
2. No change
3. No change
4. No change
5. No change
6. No change

~~R9-7-503.~~ R9-7-502. Child Life Services

No change

1. No change
2. No change
3. No change
4. No change
 - a. No change
 - b. No change
 - c. No change
5. No change

~~R9-7-504.~~ R9-7-503. Education Coordination

The Department shall provide the following education coordination:

1. No change
2. No change
3. Consulting with the member, the member's family, and school personnel regarding the member's transition under ~~R9-7-505~~ R9-7-504;
4. No change
5. No change

~~R9-7-505.~~ R9-7-504. Transition Services

A. No change

~~B.~~ ~~When a member is 14 years of age, the Department shall develop and implement an on-going plan to transition the member from pediatric care to adult care that:~~

B. The Department shall, at an appropriate time based on the member's age and the member's CRS condition, as determined by a CRS provider, develop and implement an on-going plan to transition the member from pediatric care to adult care that:

1. No change
2. No change

~~R9-7-506.~~ R9-7-505. Transportation Services

The Department shall provide transportation to a member:

1. From a ~~regional clinic or an outreach clinic~~ location where a CRS provider is evaluating or treating the member to a hospital that is a CRS provider, if medically necessary to respond to an immediate threat to the life or health of the member; or
2. No change

R9-7-506. Renumbered

ARTICLE 6. ~~MEMBER PAYMENT~~ REPEALED

R9-7-601. General Requirements Repealed

- A.** The Department shall determine an applicant's or member's payment responsibility for covered medical services by:
1. Identifying the applicant's or member's household income group;
 2. Calculating the net income of the applicant's or member's household income group by subtracting allowable deductions in R9-7-603 from the gross income of the applicant's or member's household income group; and
 3. Determining whether the net income of the member's household income group is:
 - a. At or below 200% of the Federal Poverty Level; or
 - b. More than 200% of the Federal Poverty Level.
- B.** Before the Department enrolls an applicant, the applicant or, if the applicant is a minor, the applicant's parent, shall sign a payment agreement containing:
1. The applicant's name;
 2. The applicant's date of birth;
 3. The applicant's payment responsibility established according to R9-7-604;
 4. A promise to pay the cost of covered medical services up to the total amount of any:
 - a. Court award or settlement of a claim related to the applicant's CRS condition, less money from the court award or settlement expended by the applicant for medical services;
 - b. Health care insurance payment or reimbursement to which the applicant is entitled for the covered medical services; and
 - e. Other third party payment or reimbursement to which the applicant is entitled for the covered medical services;
 5. A promise to pay according to the applicant's payment responsibility for covered medical services when subsection (B)(4) does not apply;
 6. An assignment of insurance benefits;
 7. The expiration date of the payment agreement;
 8. The gross income of the applicant's household income group;
 9. Total deductions;
 10. The number of individuals in the applicant's household income group;
 11. The signature of the applicant or, if the applicant is a minor, the applicant's parent and date signed; and
 12. The signature of the Department's representative and date signed.

R9-7-602. Renumbered

R9-7-603. Renumbered

R9-7-604. Renumbered

ARTICLE 7. MEMBER APPEALS

R9-7-701. Member Appeals

- A.** For purposes of this Article, "appeal":
1. Means a written expression of dissatisfaction with a ~~regional contractor's~~ CRS provider's intended decision not to provide a covered service to a member that is submitted to the Department by the member or, if the member is a minor, the member's parent; or
 2. No change
- B.** No change
- C.** No change
- D.** If a member or, if the member is a minor, the member's parent, does not submit an appeal within 60 days from the date of a ~~regional contractor's~~ CRS provider's intended decision, the intended decision becomes final.
- E.** To submit an appeal of a ~~regional contractor's~~ CRS provider's intended decision not to provide covered services, a member shall submit to the Department, no later than 60 ~~calendar~~ days from the date of the intended decision that is the subject of the appeal, a written notice containing:
1. No change
 2. No change
 3. No change
 4. No change
- F.** The Department shall provide a member or, if the member is a minor, the member's parent with written notification regarding an appeal within 30 days from the date of receiving the appeal as follows.
1. If the Department determines that additional documentation or information is necessary to make a decision, the Department shall provide a written notice to the member requesting that the member provide the additional documentation or information within 14 ~~calendar~~ days after the date of the request.
 - a. If the member submits the requested additional documentation or information in subsection (F)(1) within 14 ~~ea-~~

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~~endar~~ days from the date of the Department's request, the Department shall, within 14 ~~calendar~~ days from the date of receiving the requested additional documentation or information, provide notice to the member according to subsection (F)(2) or (F)(3).

b. If the member does not submit the requested additional documentation or information within 14 ~~calendar~~ days from the date of the Department's request, the Department shall consider the appeal withdrawn.

2. If the Department determines that the ~~regional contractor's~~ CRS provider's intended decision does not comply with A.R.S. Title 36, Chapter 2, Article 3 or this Chapter, the Department shall reverse the intended decision and provide written notice of the Department's decision to the member and the ~~regional contractor~~ CRS provider.

3. If the Department determines that the ~~regional contractor's~~ CRS provider's intended decision complies with A.R.S. Title 36, Chapter 2, Article 3 or this Chapter, the Department shall provide a written notice of the Department's decision to the:

a. Member that complies with A.R.S. § ~~41-1092~~ 41-1092.03, and

b. ~~Regional contractor of the Department's decision-~~ CRS provider.

G. No change

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM

[R08-298]

PREAMBLE

1. Sections Affected

Article 8
R9-28-801
R9-28-801.01
R9-28-802
R9-28-803
R9-28-804
R9-28-805
R9-28-806
R9-28-807
R9-28-901
R9-28-910
R9-28-911
R9-28-913
R9-28-914
R9-28-915
R9-28-916
R9-28-917
R9-28-918
R9-28-919

Rulemaking Action

New Article
New Section
Amend
Amend
Amend
Amend
Amend
Amend
Amend
Amend
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. §§ 36-2935, 36-2956

Implementing statute: A.R.S. §§ 36-2935, 36-2956

3. The effective date of the rules:

November 8, 2008

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 2244, June 6, 2008

Notice of Proposed Rulemaking: 14 A.A.R. 2314, June 13, 2008

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

The AHCCCS Administration proposes to amend the Sections identified above as a result of a Five-year Review Report approved by the Governor's Regulatory Review Council on May 6, 2008. The subjects requiring amendment are the definitions, payor of last resort requirements, cost avoidance requirements and other technical changes. The rules on liens under the Tax Equity and Fiscal Responsibility Act (TEFRA liens) are being moved from Article 9 to Article 8.

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

No study was reviewed during this rulemaking and the Agency does not anticipate reviewing any studies.

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:

It is anticipated that the contractors, private sector, members, providers, small businesses, political subdivisions, the Department, and the Administration will be minimally impacted by the changes to the rule language. The areas requiring revision are for clarity as a result of a Five-year Rule Review approved by the Governor's Regulatory Review Council.

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

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

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

No public comments were received for 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:

Not applicable

14. Whether the rules were previously made as emergency rules and if so, whether the text was changed between the making as an emergency and the making of the final rules:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 8. ~~REPEALED~~ TEFRA LIENS AND RECOVERIES

Section

- R9-28-801. ~~Repealed~~ Definitions Related to TEFRA Liens
- R9-28-801.01. ~~Repealed~~ TEFRA Liens – General
- R9-28-802. ~~Repealed~~ TEFRA Liens – Affected Members
- R9-28-803. ~~Repealed~~ TEFRA Liens – Prohibitions
- R9-28-804. ~~Repealed~~ TEFRA Liens – AHCCCS Notice of Intent

Notices of Final Rulemaking

- R9-28-805. TEFRA Liens and Estate Recovery – Member’s Request for a State Fair Hearing
- R9-28-806. TEFRA Liens – Recovery
- R9-28-807. TEFRA Liens – Release

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

Section

- R9-28-901. Definitions
- R9-28-910. Recoveries
- R9-28-911. Estate Recovery and Undue Hardship
- R9-28-912. Partial Recovery
- R9-28-913. ~~TEFRA Liens – General~~ Repealed
- R9-28-914. ~~TEFRA Liens – Affected Members~~ Repealed
- R9-28-915. ~~TEFRA Liens – Prohibitions~~ Repealed
- R9-28-916. ~~TEFRA Liens – AHCCCS Notice of Intent~~ Repealed
- R9-28-917. ~~TEFRA Liens and Estate Recovery – Member’s Request for a State Fair Hearing~~ Repealed
- R9-28-918. ~~TEFRA Liens – Recovery~~ Repealed
- R9-28-919. ~~TEFRA Liens – Release~~ Repealed

ARTICLE 8. ~~REPEALED~~ TEFRA LIENS AND RECOVERIES

R9-28-801. ~~Repealed~~ Definitions Related to TEFRA Liens

In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definitions apply to this Article:

“Consecutive days” means days following one after the other without an interruption resulting from a discharge.

“File” means the date that AHCCCS receives a request for a State Fair Hearing under R9-28-805, as established by a date stamp on the request or other record of receipt.

“Home” means property in which a member has an ownership interest and that serves as the member’s principal place of residence. This property includes the shelter in which a member resides, the land on which the shelter is located, and related outbuildings.

“Recover” means that AHCCCS takes action to collect from a claim.

“TEFRA lien” means a lien under 42 U.S.C. 1396p of the Tax Equity and Fiscal Responsibility Act of 1982.

R9-28-801.01. ~~TEFRA Liens – General~~

Purpose. The purpose of TEFRA is to allow AHCCCS to file a lien on an AHCCCS member’s interest in any real property before the member is deceased, including but not limited to life estates and beneficiary deeds.

R9-28-802. ~~Repealed~~ TEFRA Liens – Affected Members

A. Except for members under R9-28-803, AHCCCS shall file a TEFRA lien against the real property of all members who are:

1. Receiving ALTCS services,
2. 55 years of age or older, and
3. Permanently institutionalized.

B. A rebuttable presumption exists that a member is permanently institutionalized if the member has continually resided in a nursing facility, ICF/MR, or other medical institution defined in 42 CFR 435.1010 for 90 or more consecutive days. A member may rebut the presumption by providing a written opinion from a treating physician, rendered to a reasonable degree of medical certainty, that the member’s condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a date certain.

R9-28-803. ~~Repealed~~ TEFRA Liens – Prohibitions

AHCCCS shall not file a TEFRA lien against a member’s home if one of the following individuals is lawfully residing in the member’s home:

1. Member’s spouse;
2. Member’s child who is under the age of 21;
3. Member’s child who is blind or disabled under 42 U.S.C. 1382c; or
4. Member’s sibling who has an equity interest in the home and who was residing in the member’s home for at least one year immediately before the date the member was admitted to a nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010.

R9-28-804. ~~Repealed~~ TEFRA Liens – AHCCCS Notice of Intent

A. Time-frame. At least 30 days before filing a TEFRA lien, AHCCCS shall send the member or member’s representative a Notice of Intent.

Notices of Final Rulemaking

- B.** Content of the Notice of Intent. The Notice of Intent shall include the following information:
1. A description of a TEFRA lien and the action that AHCCCS intends to take.
 2. How a TEFRA lien affects a member's property.
 3. The legal authority for filing a TEFRA lien.
 4. The time-frames and procedures involved in filing a TEFRA lien, and
 5. The member's right to request an exemption.
- C.** Request for exemption. A member or a member's representative may request an exemption. To request an exemption the member or the member's representative shall submit a written statement to AHCCCS within 30 days from the receipt of the Notice of Intent describing the factual basis for a claim that the property should be exempt from placement of a TEFRA lien or from recovery of lien based on R9-28-802, R9-28-803, or R9-28-806. AHCCCS shall respond to the member or member's representative in writing within 30 days of receiving a request for exemption, unless the parties mutually agree to a longer period of time.

R9-28-805. TEFRA Liens and Estate Recovery – Member's Request for a State Fair Hearing

- A.** If the member or member's representative does not request an exemption under R9-28-804(C), the Administration shall send the member or representative a Notice of TEFRA Lien. The member or representative may file a request for a State Fair Hearing within 30 days of the receipt of the Notice of TEFRA Lien.
- B.** If the member requests an exemption and the request is denied, the Administration shall send the member or representative a Denial of a Request for Exemption. The member or representative may file a request for a State Fair Hearing within 30 days of the receipt of the Denial of Request for Exemption. After the 30-day time-frame to file a State Fair Hearing, the member or representative is sent a Notice of a TEFRA Lien.
- C.** Hearings regarding TEFRA liens shall be conducted under 9 A.A.C. 34.

R9-28-806. TEFRA Liens – Recovery

- A.** AHCCCS shall seek to recover a TEFRA lien upon the sale or transfer of the real property subject to the lien. However, AHCCCS shall not seek to recover the TEFRA lien or attempt recovery against any real property subject to the TEFRA lien so long as the member is survived by the member's:
1. Spouse;
 2. Child under the age of 21; or
 3. Child who receives benefits under either Title II or Title XVI of the Social Security Act as blind or disabled, as defined under 42 U.S.C. 1382c.
- B.** AHCCCS shall not seek to recover a TEFRA lien on an individual's home if the member is survived by:
1. A sibling of the member who currently resides in the deceased member's home and who was residing in the member's home for a period of at least one year immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010; or
 2. A child of the member who resides in the deceased member's home and who:
 - a. Was residing in the member's home for a period of at least two years immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010; and
 - b. Provided care to the member that allowed the member to reside at home rather than in an institution.
- C.** To determine whether a child of the member provided care under subsection (B)(2), AHCCCS shall require the following information:
1. A physician's written statement that describes the member's physical condition and service needs for the previous two years before the member's death;
 2. Verification that the child actually lived in the member's home;
 3. A written statement from the child providing the services that describes and attests to the services provided;
 4. A written statement, if any, made by the member prior to death regarding the services received; and
 5. A written statement from physician, friend, or relative as witness to the care provided.

R9-28-807. TEFRA Liens – Release

AHCCCS shall issue a release of a TEFRA lien within 30 days of:

1. Satisfaction of the lien;
2. Notice that the member has been discharged from the nursing facility, ICF/MR, or other medical institution, defined under 42 CFR 435.1010, and the member has returned home and is physically residing in the home with the intention of remaining in the home. Discharge to an alternative HCBS setting defined at R9-28-101 does not constitute a return to the home; or
3. Notice of the member's death, if a lien has been filed on a life estate.

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

R9-28-901. Definitions

In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the follow-

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ing definitions apply to this Article:

1. ~~“Consecutive days” means days following one after the other without an interruption based on discharge.~~
2. ~~“Estate” has the meaning in A.R.S. § 14-1201.~~
3. ~~“File” means the date that AHCCCS receives a request for a State Fair Hearing under R9-28-917, as established by a date stamp on the request or other record of receipt.~~
4. ~~“Home” means property in which a member has an ownership interest and which serves as the member’s principal place of residence. This property includes the shelter in which a member resides, the land on which the shelter is located, and related outbuildings.~~
5. ~~“Member” means a person eligible for AHCCCS-covered services under A.R.S. Title 36, Chapter 29, Article 2.~~
6. ~~“Place” means AHCCCS recording a lien on a member’s property with the judicial system.~~
7. ~~“Recover” means that AHCCCS takes action to collect from a claim.~~
8. ~~“TEFRA lien” means a lien under 42 U.S.C. 1396p of the Tax Equity and Fiscal Responsibility Act of 1982.~~

R9-28-910. Recoveries

AHCCCS shall recover funds paid before or after the death of a member for ALTCS benefits including: capitation payments, Medicare Parts A and B premium payments, coinsurance and deductibles paid by AHCCCS, fee-for-service payments, and reinsurance payments from:

1. The estate of a member who was 55 years of age or older when the member received benefits; or
2. The estate or the property of a member under A.R.S. §§ 36-2935, 36-2956, and 42 U.S.C. 1396p.

R9-28-911. Estate Recovery and Undue Hardship

A. Any recovery of a claim by AHCCCS against a member’s estate shall be made only after the death of the member’s surviving spouse and only at a time:

1. When there exists no surviving minor child under age 21; and
2. When there exists no surviving child who receives benefits under either Title II or Title XVI of the Social Security Act because the child is blind or disabled as defined in 42 U.S.C. 1382c.

B. Undue hardship exemption request. A member’s representative may request an undue hardship exemption. If the member’s representative wishes to request an undue hardship exemption, ~~the member’s representative shall submit the request~~ within 30 days from the receipt of the notification of the AHCCCS claim against the estate, ~~the~~ The member’s representative shall submit a written statement to AHCCCS describing the factual basis for a claim that the property should be exempt from estate recovery as provided under this Section. AHCCCS shall respond to the member or member’s representative in writing within 30 days of receiving an undue hardship exemption request, unless the parties mutually agree to a longer period of time.

C. AHCCCS shall waive a claim against a member’s estate because of undue hardship if any of the following situations exist:

1. The estate consists only of real property that is listed as residential property by the Arizona Department of Revenue or County Assessor’s Office, and the heir or devisee:
 - a. Owns a business that is located at the residential property and:
 - i. The business was in operation at the residential property for at least 12 months preceding the death of the member,
 - ii. The business provides more than 50 percent of the heir’s or devisee’s livelihood, and
 - iii. The recovery of the property would result in the heir or devisee losing the heir’s or devisee’s means of livelihood; or
 - b. Currently resides in the residence and:
 - i. Resided there at the time of the member’s death,
 - ii. Made the residence his or her primary residence for the 12 months immediately before the death of the member, and
 - iii. Owns no other residence; or
2. The estate consists only of personal property; and:
 - a. ~~The heir~~ heir’s or devisee’s ~~annual~~ gross annual income for the household size is less than 100 percent of the Federal Poverty Level (FPL). New sources of income such as employment or Social Security that may not have yet been received; are included in determining the household’s annual gross income; and
 - b. The heir or devisee does not own a home, land, or other real property.

D. When the estate consists of both personal property and real property that qualify for the undue hardship exemption criteria ~~at under subsection~~ subsections (B) and (C), AHCCCS shall not grant an undue hardship waiver; however, AHCCCS shall adjust its claim to the value of the personal property.

~~E. Subsections (A), (B), and (C) are not applicable to TEFRA liens.~~

~~F.E.~~ AHCCCS shall exempt the following income, resources, and property of Native Americans (NA) and Alaska Natives

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(AN) from estate recovery:

1. Income and resources from tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission or U.S. Claims Court;
2. Ownership interest in trust or non-trust property;
3. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources;
4. Any other ownership interests or rights in ~~or a~~ property ~~rights~~ that ~~have~~ has unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom; and
5. Income left as a remainder in an estate derived from any property listed in subsection (E)(1)-(4), that was either collected by a NA, or by a Tribe or Tribal organization and distributed to a NA.

R9-28-913. ~~TEFRA Liens General~~ Repealed

- ~~A. Purpose. The purpose of TEFRA is to allow AHCCCS to place a lien on an AHCCCS member's real property before the member is deceased or to place a lien on a deceased member's estate.~~
- ~~B. Life estates and beneficiary deeds. Except for members under R9-28-915, AHCCCS shall place a TEFRA lien on a member's real property interest held in a life estate or beneficiary deed created before or after the member's eligibility. Except for members under R9-28-918, AHCCCS shall enforce recovery against the remainder beneficiary following the member's death or upon transfer of the property.~~
- ~~C. Recovery. As provided under R9-28-918, AHCCCS shall recover a TEFRA lien under R9-28-910.~~

R9-28-914. ~~TEFRA Liens Affected Members~~ Repealed

- ~~A. Except for members under R9-28-915, AHCCCS shall place a TEFRA lien against the real property of all members who are:~~
- ~~1. Receiving ALTCS services;~~
 - ~~2. 55 years of age or older, and~~
 - ~~3. Permanently institutionalized.~~
- ~~B. A rebuttable presumption exists that a member is permanently institutionalized if the member has continually resided in a nursing facility, ICF/MR, or other medical institution defined in 42 CFR 435.1009 for 90 or more consecutive days. A member may rebut the presumption by providing a written opinion from a treating physician, rendered to a reasonable degree of medical certainty, that the member's condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a date certain.~~

R9-28-915. ~~TEFRA Liens Prohibitions~~ Repealed

- ~~AHCCCS shall not place a TEFRA lien against a member's home if one of the following individuals is lawfully residing in the member's home:~~
- ~~1. Member's spouse;~~
 - ~~2. Member's child who is under the age of 21;~~
 - ~~3. Member's child who is blind or disabled under 42 U.S.C. 1382c; or~~
 - ~~4. Member's sibling who has an equity interest in the home and who was residing in the member's home for at least one year immediately before the date the member was admitted to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1009.~~

R9-28-916. ~~TEFRA Liens AHCCCS Notice of Intent~~ Repealed

- ~~A. Time frame. At least 30 days before filing a TEFRA lien, AHCCCS shall send the member or member's representative a Notice of Intent.~~
- ~~B. Content of the notice of intent. The Notice of Intent shall include the following information:~~
- ~~1. A description of a TEFRA lien and the action that AHCCCS intends to take;~~
 - ~~2. How a TEFRA lien affects a member's property;~~
 - ~~3. The legal authority for filing a TEFRA lien;~~
 - ~~4. The time frames and procedures involved in filing a TEFRA lien;~~
 - ~~5. The member's right to request a State Fair Hearing; and~~
 - ~~6. The process and time frames for requesting a State Fair Hearing.~~
- ~~C. Request for exemption. A member's representative may request an exemption. To request an exemption the member or the member's representative shall submit a written statement to AHCCCS within 30 days from the receipt of the Notice of Intent describing the factual basis for a claim that the property should be exempt from placement of a TEFRA lien or from recovery of lien based on R9-28-914(B), R9-28-915 or R9-28-918. AHCCCS shall respond to the member or member's representative in writing within 30 days of receiving a request for exemption, unless the parties mutually agree to a longer period of time.~~

R9-28-917. ~~TEFRA Liens and Estate Recovery Member's Request for a State Fair Hearing~~ Repealed

- ~~A. A member or member's representative may request a State Fair Hearing:~~

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1. Within 30 days of the receipt of AHCCCS' Notice of Intent or notification of AHCCCS' claim against the estate; or
2. Within 30 days of receipt of a denial of a request for exemption under R9-28-916(C) or denial of a request to waive estate recovery because of undue hardship under R9-28-911(B).

~~B. Hearings regarding AHCCCS' intent to place a TEFRA lien shall be conducted under A.A.C. Title 9, Chapter 34, Article 1.~~

R9-28-918. ~~TEFRA Liens Recovery Repealed~~

~~A. AHCCCS shall seek to recover a TEFRA lien upon the sale or transfer of the real property subject to the lien. However, AHCCCS shall not seek to recover the TEFRA lien or attempt recovery against any real property subject to the TEFRA lien so long as the member is survived by the member's:~~

1. Spouse;
2. Child under the age of 21; or
3. Child who receives benefits under either Title II or Title XVI of the Social Security Act as blind or disabled, as defined under 42 U.S.C. 1382e.

~~B. AHCCCS shall not recover a TEFRA lien on an individual's home if the member is survived by:~~

1. A sibling of the member who currently resides in the deceased member's home and who was residing in the member's home for a period of at least one year immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1009; or
2. A child of the member resides in the deceased member's home who:
 - a. Was residing in the member's home for a period of at least two years immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1009; and
 - b. Provided care to the member, which allowed the member to reside at home rather than in an institution.

~~C. To determine whether a child of the member provided care under subsection (B)(2), AHCCCS shall require the following information:~~

1. Physician's statement that describes the member's physical condition and service needs for the previous two years;
2. Verification that the child actually lived in the member's home;
3. Statement from the child providing the services that describes and attests to the services provided;
4. Any statement made by the member prior to death regarding the services received; and
5. Statement from physician, friend, or relative as witness to the care provided.

R9-28-919. ~~TEFRA Liens Release Repealed~~

~~AHCCCS shall issue a release of a TEFRA lien within 30 days of:~~

1. Satisfaction of the lien; or
2. Notice that the member has been discharged from the nursing facility, ICF/MR, or other medical institution, defined under 42 CFR 435.1009, and the member has returned home and is physically residing in the home with the intention of remaining in the home. Discharge to an alternative HCBS setting defined at R9-28-101(B) does not constitute a return to the home.

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERCIAL PROGRAMS

[R08-317]

PREAMBLE

1. Sections Affected

R17-5-201
R17-5-202
R17-5-203
R17-5-204
R17-5-205
R17-5-206
R17-5-207
R17-5-208
R17-5-208

Rulemaking Action

Amend
Amend
Amend
Amend
Amend
Amend
Amend
Repeal
New Section

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- 2. The statutory 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. § 28-3223
- 3. The effective date of the rules:**
November 8, 2008
- 4. A list of all previous notices appearing in the Register addressing the final rule:**
Notice of Rulemaking Docket Opening: 13 A.A.R. 4147, November 23, 2007
Notice of Proposed Rulemaking: 14 A.A.R. 1274, April 25, 2008
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Celeste M. Cook, Administrative Rules Analyst
Address: Administrative Rule Unit
Department of Transportation, Motor Vehicle Division
1801 W. Jefferson St., Mail Drop 530M
Phoenix, AZ 85007

Telephone: (602) 712-7624
Fax: (602) 712-3081
E-mail: ccook@azdot.gov

Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.azdot.gov/mvd/MVDRules/rules.asp.
- 6. An explanation of the rule, including the agency's reason for initiating the rule:**
The Division proposes to amend these rules to establish a permanent waiver process for intrastate drivers who are disqualified from driving a commercial motor vehicle as prescribed in 49 CFR 391.41(b)(3), but who are otherwise qualified, to apply for a waiver, restricted to the state of Arizona. Changes are also made to ensure conformity to Arizona Administrative Procedure Act, the Secretary of State, and the Governor's Regulatory Review Council rulemaking format and style requirements.
- 7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
November 2001. Publication No. FMCSA-MCRT-02-001: Tech Brief: Qualifying Individuals with Insulin-Treated Diabetes to Operate Commercial Motor Vehicles. An interested party may obtain a copy of the study by contacting Sandy Zywockarte, Chief of Physical Qualifications Division, Department of Transportation, Federal Motor Carrier Safety Administration, MC-PSD, 400 Seventh St., SW, Washington, DC 20590 or view the study via the following hyperlink; <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>.
- 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 is no economic impact resulting from the amendments of these rules other than the resources necessary for rulemaking.
- 10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
The proposed rulemaking contained an earlier version of R17-4-203. R17-5-203(D) was revised to make an amendment to 49 CFR 390.19.

An internal review resulted in a decision to clarify the waiver application process.

The final rulemaking does not strike the amendment made to the incorporated 49 CFR 390.21. The final rule corrects this error by providing the most recently codified base text.

In addition, minor grammatical and style corrections were made at the request of Governor's Regulatory Review Council staff.
- 11. A summary of the comments made regarding the rule 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:**
Not applicable

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

In R17-5-202: 49 CFR 40, 382, 390, 391, 392, 393, 395, 396, 397, and 399, published October 1, 2005, and no later amendments or editions.

14. Whether the rules were previously made as emergency rules and if so, whether the text was changed between the making as an emergency and the making of the final rules:

No

15. The full text of the rules follows:

TITLE 17. TRANSPORTATION

**CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERCIAL PROGRAMS**

ARTICLE 2. MOTOR CARRIERS

Section

- R17-5-201. Definitions
- R17-5-202. Motor Carrier Safety: Incorporation of Federal Regulations; Application
- R17-5-203. Motor Carrier Safety: 49 CFR 390 – Federal Motor Carrier Safety Regulations; General Applicability and Definitions; General Requirements and Information
- R17-5-204. Motor Carrier Safety: 49 CFR 391 – Qualifications of Drivers
- R17-5-205. Motor Carrier Safety: 49 CFR 382 – Controlled Substances and Alcohol Use and Testing
- R17-5-206. Motor Carrier Safety: Amendment to 49 CFR 392
- R17-5-207. Civil Penalties
- ~~R17-5-208. Insulin-dependent Commercial Driver License Waiver Pilot Study Program~~
- R17-5-208. Commercial Driver License Insulin-dependent Diabetic Waiver

ARTICLE 2. MOTOR CARRIERS

R17-5-201. Definitions

~~A. The following definitions apply to this Article unless context indicates otherwise:~~

A. In addition to the definitions provided under A.R.S. § 28-3001, the following definitions apply to this Article unless otherwise specified:

- 1. “Audit” means any inspection of a transporter’s motor vehicle, equipment, books, or records to determine compliance with this Article and A.R.S. Title 28, Chapter 14.
- 2. “Co-applicant” means an employer or potential employer.
- 3. ~~“Commercial driver license” or “CDL” has the meaning prescribed in A.R.S. § 28-3001(2).~~
- 4. “Danger to public safety” means any condition of a transporter likely to result in serious peril to the public if not discontinued immediately.
- 5. ~~“Division” or “MVD”~~ means the Motor Vehicle Division, Arizona Department of Transportation.
- 6. ~~“Division Director”~~ means the Assistant Director of the Arizona Department of Transportation for the Motor Vehicle Division or the Assistant Director’s designated agent.
- 7. “Hearing Office” means the Arizona Department of Transportation, Motor Vehicle Division, Executive Hearing Office.
- 8. “Transporter” means any person, driver, motor carrier, shipper, manufacturer, or motor vehicle, including any motor vehicle transporting a hazardous material, hazardous substance, or hazardous waste, subject to this Article and A.R.S. Title 28, Chapter 14.
- 9. “Violation” means any conduct, act, or failure to act required or prohibited under this Article and A.R.S. Title 28, Chapter 14.

B. Any definition prescribed under A.R.S. § 28-5201 also applies to this Article.

R17-5-202. Motor Carrier Safety: Incorporation of Federal Regulations; Application

A. The Division incorporates by reference 49 CFR 40, 382, 390, 391, 392, 393, 395, 396, 397, and 399, published October 1, 2005, and no later amendments or editions, as amended by under R17-5-202 through ~~R17-5-208~~ R17-5-207. The incorporated material is available from the U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, D.C. 20402-0001, and is on file with the Division.

B. The Sections of 49 CFR that are incorporated in subsection (A) apply as amended by under R17-5-203 through ~~R17-5-208~~

R17-5-207 to: all intrastate and interstate motor carriers operating in Arizona.

1. A motor carrier as defined in A.R.S. § 28-5201 except, a motor carrier transporting passengers for hire in a motor vehicle with a design capacity of seven or fewer persons.
2. A vehicle owned or operated by the state, a political subdivision, or a public authority of the state that is used to transport hazardous materials in an amount requiring the vehicle to be marked or placarded as prescribed by the federal regulations incorporated in R17-5-209.

R17-5-203. Motor Carrier Safety: 49 CFR 390 – Federal Motor Carrier Safety Regulations; General Applicability and Definitions; General Requirements and Information

- A. 49 CFR 390.3, General applicability, is amended as follows:
1. Paragraph (a) is amended to read:
Regulations incorporated in this Section are applicable to all motor carriers operating in Arizona and any vehicle owned or operated by the state, a political subdivision, or a state public authority that is used to transport a hazardous material in an amount requiring the vehicle to be marked or placarded as prescribed ~~in~~ under R17-5-209.
 2. Paragraph (b) is amended to read:
A motor carrier driver domiciled in Arizona who operates a commercial motor vehicle as defined ~~in~~ under A.R.S. § 28-3001 shall comply with the requirements of A.R.S. Title 28, Chapter 8 and any rule made under that Chapter.
 3. Paragraph (c) is amended to read:
A motor carrier operating in Arizona in furtherance of a commercial enterprise, shall comply with the financial responsibility requirement specified in A.R.S. Title 28, Chapter 9, Article 2, and 49 CFR 387.
 4. Paragraph (f)(6) is deleted.
- B. 49 CFR 390.5, Definitions. The definitions listed in 49 CFR 390.5 are amended as follows:
1. If the term “Commercial Motor Vehicle” or “CMV” is used in reference to the controlled substances and alcohol use and testing requirement of 49 CFR 382, the term has the meaning prescribed in 49 CFR 382.107.
 2. If the term “Commercial Motor Vehicle” or “CMV” is used in reference to the licensing requirements prescribed under A.R.S. § 28-3223, the term has the meaning prescribed under A.R.S. § 28-3001.
 3. If the term “Commercial Motor Vehicle” or “CMV” is not used in reference to the controlled substances and alcohol use and testing requirement of 49 CFR 382 or the licensing requirement prescribed under A.R.S. § 28-3223, the term means a self-propelled, motor-driven vehicle or vehicle combination, used on a public highway in this state in furtherance of a commercial enterprise that:
 - a. Has a gross vehicle weight rating (GVWR) as a single vehicle or a gross combination weight rating (GCWR) of 18,001 pounds or more for purposes of intrastate commerce;
 - b. Transports passengers for hire and has a design capacity of eight or more persons or transports a hazardous material in an amount requiring marking or placarding as prescribed by the federal regulations incorporated in R17-5-209;
 - c. Is not an intrastate-operating tow truck that has a GVWR of 26,000 pounds or less, but a tow truck operator remains subject to all other provisions prescribed under 49 CFR 391.41, 391.43, 391.45, 391.47, and 391.49; ~~and~~ or
 - d. Operates for purposes of interstate commerce with a GVWR of greater than 10,000 pounds.
 4. “Exempt intracity zone” is deleted and has no application in R17-5-203 through ~~R17-5-208~~ R17-5-207.
 5. “For-hire motor carrier,” “private motor carrier,” “private motor carrier of passengers (business),” and “private motor carrier of passengers (nonbusiness)” are deleted from R17-5-203 through ~~R17-5-208~~ R17-5-207 and the term “motor carrier” is substituted.
 6. “Regional Director of Motor Carriers” means the Division Director of the Arizona Department of Transportation, Motor Vehicle Division.
 7. “Special agent” means an officer or agent of the Department of Public Safety, the Division, or a political subdivision, who is trained and certified by the Department of Public Safety to enforce Arizona’s Motor Carrier Safety requirements.
 8. “State” means a state of the United States or the District of Columbia.
 9. “Tow truck,” as used in the definition of emergency in 49 CFR 390.5, has the meaning prescribed under A.A.C. R13-3-101.
- C. 49 CFR 390.15, Assistance in investigations and special studies. Paragraph (a) is amended to read:
A motor carrier shall make all records and information pertaining to an accident available to a special agent upon request or as part of any inquiry within the time the request or inquiry specifies. A motor carrier shall give a special agent all reasonable assistance in the investigation of any accident including providing a full, true, and correct answer to any question of the inquiry.
- D. 49 CFR 390.19 Motor carrier identification report, Paragraph (a) is amended to read:
(a) Each motor carrier that conducts operations in interstate commerce, intrastate commerce if the carrier requires a Safety Permit as per 49 CFR 385.400 of this Chapter, or intrastate commerce in a CMV defined under A.A.C. R17-5-203(B)(3) shall file a Motor Carrier Identification Report, Form MCS-150, or the Combined Motor Carrier Identification

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Report and HM Permit Application, Form MCS-150B for permitted carriers, at the following times:

- (1) Before it begins operations; and
- (2) Every 24 months, according to the following schedule:

USDOT Number ending in:	Must file by last day of:
1	January
2	February
3	March
4	April
5	May
6	June
7	July
8	August
9	September
0	October

- (3) If the next-to-last digit of its USDOT number is odd, the motor carrier shall file its update in every odd-numbered calendar year. If the next-to-last digit of the USDOT number is even, the motor carrier shall file its update in every even-numbered calendar year.

E. 49 CFR § 390.21 Marking of CMVs. Paragraph (a) is amended to read:

(a) General. Every self-propelled CMV listed under A.A.C. R17-5-203(B)(3), subject to subchapter B of this Chapter shall be marked as specified in paragraph (b), (c), and (d) of 49 CFR 390.21.

F. 49 CFR 390.23, Relief from regulations.

1. Paragraph (a) is amended to read:

Regulations contained in 49 CFR 390 through 397 do not apply to a motor carrier that:

- a. Is exempt from federal jurisdiction, and
 - b. Operates a commercial motor vehicle used or designated to provide relief during an emergency.
2. Paragraphs (a)(1), including (a)(1)(i), (a)(1)(i)(A), (a)(1)(i)(B), and (a)(1)(ii) are deleted.
 3. Paragraph (a)(2)(i)(A) is amended ~~as follows to read:~~
 - a. An emergency has been declared by a federal, state, or local government official having authority to declare an emergency; or
 - b. An emergency situation exists under A.R.S. § 28-5234(B) as ~~delineated in~~ defined under R17-5-210.
 4. Paragraph (a)(2)(i)(B) is amended ~~as follows to read:~~

The Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau ~~determines~~ shall determine whether a local emergency exists that justifies an exemption from any or all of these Parts. If the Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau determines relief from these regulations is necessary to provide vital service to the public, relief shall be granted with any restrictions the Arizona Department of Public Safety considers necessary.
 5. "Interstate commerce" as used in paragraph (b) means engagement in a commercial enterprise.

G. 49 CFR 390.25, Extension of relief from regulations - emergencies is amended ~~as follows to read:~~

A motor carrier seeking to extend a period of relief from these regulations shall obtain approval from the Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau. The motor carrier shall give full details of the additional relief requested. The Arizona Department of Public Safety shall observe time limits for emergency relief from regulations as prescribed under 49 CFR 390.23(a), but may extend a period of relief after considering:

1. Severity of the emergency,
2. Nature of relief services to be provided by the motor carrier, and
3. Other restrictions that may be necessary.

H. 49 CFR 390.27, Locations of motor carrier safety service centers, is amended to read:

A motor carrier requesting relief from these regulations shall contact the Arizona Department of Public Safety, Commercial Vehicle Enforcement Bureau, Telephone (602) 223-2212.

R17-5-204. Motor Carrier Safety: 49 CFR 391 – Qualifications of Drivers

A. 49 CFR 391.11 Qualifications of drivers. Paragraph (b)(1) is amended to read:

Is at least 21 years of age for interstate operation and at least 18 years of age for operations restricted to intrastate transportation not involving the transportation of a reportable quantity of hazardous substance, hazardous waste required to be manifested, or hazardous material in an amount requiring a vehicle to be marked or placarded as prescribed ~~in~~ under R17-5-209.

B. 49 CFR 391.49 Alternative physical qualification standards for the loss or impairment of limbs.

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1. Paragraph (a) is amended by adding:
A person not physically qualified to drive as prescribed ~~in~~ under 49 CFR 391.41(b)(1), (b)(2), (b)(3), or (b)(10) but otherwise qualified to drive a motor vehicle, may drive a motor vehicle in intrastate commerce if the ~~Division~~ Director grants an intrastate waiver to the person. Application for an intrastate waiver shall be submitted according to subsection (C). If granted, an intrastate waiver shall be for a period not ~~exceeding~~ to exceed two years. A person granted an intrastate waiver may transfer the intrastate waiver from an original employer to a new employer upon written notification to the ~~Division~~ Director stating the new employer's name and the type of equipment to be driven.
2. Paragraph (b) is amended by adding:
To obtain an intrastate waiver, an applicant or an applicant and co-applicant shall submit a letter of application for an intrastate waiver of a physical qualification to the Motor Vehicle Division, Medical Review Program, P.O. Box 2100, Mail Drop 818Z, Phoenix, Arizona 85001-2100. The applicant shall comply with all the requirements of 49 CFR 391.49(c), "Alternative physical qualification standards for the loss or impairment of limbs," ~~except paragraphs (e)(1)(i) and (e)(1)(iii).~~ The driver applicant shall respond to the requirements of ~~49 CFR 391.49(e)(2)(ii)~~ 49 CFR 391.49(c)(2)(i) through (c)(2)(v), if the information is known.
3. Paragraph (c)(1)(iv) is amended to read:
A description of the driver applicant's limb or visual impairment ~~for which~~ as applicable to the type of waiver is being requested.
4. Paragraph (d)(3)(i) is amended to read:
The medical evaluation summary for a driver applicant disqualified under 49 CFR 391.41(b)(1) or (b)(10) shall include:
5. Paragraph (d)(3)(i)(B) is amended ~~by adding to read:~~
~~Or a statement by the examiner that an applicant for an intrastate waiver has:~~
 - a. ~~Distant visual acuity at least 20/40 (Snellen), with or without a corrective lens, in one eye;~~
 - b. ~~Field of vision at least 70° peripheral measurement of the horizontal meridian of the applicant's dominant eye;~~
 - e. ~~Ability to distinguish the colors of a traffic signal or device showing standard red, green, and amber.~~A statement by the examiner that the applicant is capable of demonstrating precision prehension (e.g., manipulating knobs and switches) and power grasp prehension (e.g., holding and maneuvering the steering wheel) with each upper limb separately when the intrastate waiver is requested due to a loss or impairment of limbs or a statement by the examiner that an applicant has distant visual acuity at least 20/40 (Snellen), with or without a corrective lens, in one eye, visual field of at least 70° peripheral measurement of the horizontal meridian of the applicant's dominant eye, and the ability to distinguish the colors of a traffic signal or device showing standard red, green, and amber, as applicable to the type of waiver being requested.
6. Paragraph (d)(3)(iii) is added:
~~A medical evaluation for a driver applicant disqualified as prescribed under 49 CFR 391.41(b)(3) shall include the requirements in 49 CFR 391.64.~~
- ~~7-6.~~ Paragraph (j)(1) is amended by adding:
A person with a distant visual acuity of greater than 20/40 (Snellen), with or without a corrective lens, in one eye; a field of vision of less than 70° peripheral measurement of the horizontal meridian of the person's dominant eye; and the inability to distinguish the colors of a traffic signal or device showing standard red, green and amber, shall not:
 - a. Transport any amount of hazardous material required to be marked or placarded as prescribed under R17-5-209, or
 - b. Operate a vehicle for the purpose of transporting passengers as prescribed under R17-5-202.
- C. Waiver procedure for an intrastate driver.
 - ~~1. The Division Director shall appoint the Division's Medical Review Officer to review a request for physical waiver.~~
 - ~~2. The Medical Review Officer shall:~~
 1. A person not physically qualified to drive as prescribed under 49 CFR 391.41(b)(1), (b)(2), or (b)(10) but otherwise qualified to drive a motor vehicle, may drive a motor vehicle intrastate commerce if the Director grants an intrastate waiver to the person.
 2. The applicant shall submit an application to the Division as prescribed under 49 CFR 391.49(a), (b), (c), and (d) as amended under this Section.
 3. ~~The applicant shall submit an application to the Division as prescribed under 49 CFR 391.49(a), (b), (c), and (d) as amended by this Section.~~ Upon receipt of an application for an intrastate waiver, the Director shall:
 - a. Review ~~an~~ the application for waiver to ensure all provisions of 49 CFR 391.49 are met;
 - b. Take necessary testimony and accept documentation and information about the application;
 - c. Ensure that a driver applying for an intrastate waiver of the visual requirements:
 - i. Has driven the type of vehicle to be operated as prescribed in the waiver for at least two of the previous five years; and
 - ii. Will not transport passengers for hire, or
 - iii. Will not transport a reportable quantity of a hazardous substance, hazardous waste that requires a manifest,

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- or hazardous material that requires marking or placarding as prescribed under R17-5-209;
- d. ~~Notify the applicant by mail:~~
 - d. Send written and dated notification of the approval or denial of the applicant's request for a waiver to the applicant within 10 days of the decision. The notice shall:
 - i. ~~To Direct the approved applicant to contact the nearest CDL examiner Commercial Driver Licensing office to schedule a time to take the CDL commercial driver license pre-inspection, off-road, and on-road tests within 30 days from date of notice; and or~~
 - ii. ~~Of the approval or denial of the waiver within 10 days of the decision to approve or deny.~~
 - ii. Inform the denied applicant of the right to a hearing and the procedure for requesting an administrative hearing. The administrative hearing is held in accordance with the procedures prescribed under 17 A.A.C. 1, Article 5.
4. ~~Waiver Intrastate waiver form.~~
- a. ~~The Division Director shall ensure that the application for waiver form reflects the terms, conditions, or limitations of the waiver.~~
 - b. ~~The Division Director shall maintain the original waiver form.~~
 - c. ~~The motor carrier shall retain a legible copy of the waiver form:~~
 - i. ~~During the driver's employment as a driver, and~~
 - ii. ~~For a minimum of three years after the driver ceases driving for the motor carrier.~~
 - d. ~~A driver granted a waiver shall possess a legible copy of the waiver when driving a commercial motor vehicle.~~
5. ~~Hearings and appeals. If the Medical Review Officer denies a waiver application, the applicant may request a hearing with the MVD Executive Hearing Office within 15 days from the date of the notice as prescribed under 17 A.A.C. 1, Article 5.~~
6. ~~Using the U.S. Department of Transportation Federal Highway Administration's Regulatory Criteria for Evaluation under Section 391.41, April 1996, the Medical Review Officer may suspend for life the commercial vehicle operating privilege of any driver who, after issuance of a waiver as prescribed in this Section:~~
- a. ~~Fails to meet the conditions imposed by this Section;~~
 - b. ~~Commits a serious traffic violation described under A.R.S. § 28-3312(E), or~~
 - e. ~~Is involved in a reportable accident related to the driver's medical condition.~~
- 7.5. ~~If the enforcement of any provision of this Section would result in the loss or disqualification of federal funding for any state agency or program, that provision is invalid.~~
- D. Subpart F - Files and Records. 49 CFR 391.51 General requirements for driver qualification files. Paragraph (b)(8) is amended by adding:
"or the ~~Division~~ Director's letter of notification, granting an intrastate waiver of physical disqualification, if a waiver is granted as prescribed ~~in~~ under this Section."
- E. The following sections are deleted:
- 1. 49 CFR 391.68 Private motor carrier of passengers (nonbusiness).
 - 2. 49 CFR 391.69 Private motor carrier of passengers (business).

R17-5-205. Motor Carrier Safety: 49 CFR 382 – Controlled Substances and Alcohol Use and Testing

- A. 49 CFR 382.103 Applicability. Paragraph (a)(1) is amended to read:
The commercial driver license requirements of the state of Arizona.
- B. 49 CFR 382.115 Starting date for testing programs. Paragraph (a) is amended to read:
The controlled substances and alcohol use and testing requirements ~~commence~~ begin for all motor carriers on the date this Section goes into effect.
- C. Paragraph (b) is deleted.

R17-5-206. Motor Carrier Safety: Amendment to 49 CFR 392

- A. 49 CFR 392.5 Alcohol prohibition. Paragraph (e) is amended to read:
Drivers who violate the terms of an out-of-service order as prescribed ~~in~~ under this Section are subject to the provisions and sanctions of A.R.S. § ~~28-5232~~ 28-5241.
- B. 49 CFR 392.9a is deleted.

R17-5-207. Civil penalties

To determine the amount of civil penalty for repeat findings of responsibility for the same class of violations involving vehicles required to be placarded, the higher level of civil penalty as prescribed ~~in~~ under A.R.S. § 28-5238 applies.

R17-5-208. Insulin-dependent Commercial Driver License Waiver Pilot Study Program

The Division shall create a pilot study program for insulin-dependent diabetics to process, monitor, and evaluate the feasibility of establishing a waiver program for intrastate drivers who are disqualified as prescribed ~~in~~ under the provisions of 49 CFR 391.41(b)(3), but who are otherwise qualified. All requirements of R17-5-204 apply except subsections (B)(3) and (B)(4).

- 1. ~~The Medical Review Officer, authorized to approve or deny waiver applications, shall administer the pilot study pro-~~

- gram.
2. The study program begins on the effective date of this rule and terminates two years from that date.
 3. All waivers issued through the study program terminate upon the expiration of the study program.
 4. The Division Director may extend the study or establish a permanent waiver process after review of the study program results.
 5. An insulin-dependent diabetic may apply for a waiver, restricted to the state of Arizona, for participating in the two-year pilot study if:
 - a. The applicant submits blood glucose logs to an endocrinologist or medical examiner at an annual examination or at any time as directed by the medical review section.
 - b. The applicant has a driving record meeting the minimum requirements of safe driving as specified in applicable federal and state safety regulations and has no serious traffic violation as described under A.R.S. § 28-3312(E), no period of driver disqualification, and no reportable accident for the three-year period before submitting the waiver application.
 - e. A separate signed statement from an examining ophthalmologist is submitted that the applicant has been examined and does not have unstable proliferative diabetic retinopathy, unstable advancing disease of blood vessels in the retina, and has stable acuity of at least 20/40 Snellen in each eye, with or without corrective lenses.
 6. An insulin-dependent diabetic commercial driver license applicant shall provide:
 - a. A board-certified or board-eligible endocrinologist with a complete medical history including the date insulin use began, all hospitalization reports, consultation notes for diagnostic examinations, special studies pertaining to the diabetes and follow-up reports, and reports of any hypoglycemic insulin reactions within the prior 12 months from the date the applicant started using insulin.
 - b. An examination by a board-certified or board-eligible endocrinologist. The complete medical examination shall consist of a comprehensive evaluation of the applicant's medical history and current status, including a review of:
 - i. Fasting blood studies glucose, glycosylated hemoglobin/Hb A1c I including lab reference page and urinalysis performed during the last six months; and
 - ii. Insulin dosages and types, diet utilized for control, and any significant factors such as smoking, alcohol use, and other medications or drugs taken.
 - e. A statement prepared and signed by the examining endocrinologist whose status as board-certified or board-eligible is indicated. The signed statement shall include separate declarations indicating the following medical determinations:
 - i. The endocrinologist is familiar with the applicant's medical history for the past 12 months whether through actual treatment over that time or through consultation with a physician who has treated the applicant during that time.
 - ii. The applicant is free from insulin reactions including severe hypoglycemia and hypoglycemia awareness, and has had no more than one documented hypoglycemic reaction per month in the previous 12 months from the date the applicant started using insulin injections.
 - iii. The applicant does not have severe hypoglycemia episodes of altered consciousness requiring the assistance of another person to regain control.
 - iv. The applicant does not have hypoglycemia unawareness or the inability to recognize the early symptoms of hypoglycemia such as sweating, anxiety, forceful heartbeat, and light-headedness.
 - v. The applicant's diabetic condition will not adversely affect the applicant's ability to operate a commercial motor vehicle; and
 - vi. The applicant is educated in diabetes and its management and is thoroughly informed of and understands procedures to follow to monitor and manage the applicant's diabetes and procedures to follow if complications arise.
 - d. An insulin-dependent applicant for a commercial driver license waiver shall meet the following requirements for the last three years before application:
 - i. Have a driving record that contains no suspension or revocation of the applicant's driver license for the operation of any motor vehicle, including personal vehicles, except a suspension or revocation due to nonpayment of fines;
 - ii. Have no involvement in an accident as defined in 49 CFR 390.5 for which the applicant received a citation for a moving traffic violation while operating a commercial motor vehicle;
 - iii. Have no conviction for a disqualifying offense described in 49 CFR 383.51, or more than one serious traffic violation as described in 49 CFR 383.51 and A.R.S. § 28-3312(E) while operating a commercial motor vehicle; and
 - iv. Have no more than two convictions for any non-serious moving traffic violations while operating a commercial motor vehicle.
 - e. The applicant shall immediately report any arrest, citation, or conviction to the MVD Medical Review Program.

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~~Failure to do so may result in denial or rescission of the waiver.~~

R17-5-208. Commercial Driver License Insulin-dependent Diabetic Waiver

A person not physically qualified to drive as prescribed under 49 CFR 391.41(b)(3) but otherwise qualified to drive a motor vehicle, may drive a commercial motor vehicle if the Federal Diabetes Exemption Program grants a waiver to the person. An insulin-dependent diabetic applicant may request an application for an Insulin-dependent Diabetic Waiver by contacting the Federal Diabetes Exemption Program either by telephone at (703) 448-3094 or in writing at Federal Diabetes Exemption Program, 1200 New Jersey Ave., SE, Room W64-224, Washington, DC 20590.